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ABSTRACT

This curriculum material covers the basic orientation and necessary skills which would enable the practicing Certified Nurse Assistant to be trained as a Restorative Nurse Assistant. The shift in emphasis from maintenance care to restorative care in the long-term care setting has created a need for trained paraprofessionals who are competent in the special knowledge and skills to assist in therapeutic rehabilitation as prescribed by the physical therapy, occupational therapy, and speech therapy consultants. The guide contains 33 lesson plans grouped into seven units covering the following topics: introduction to restorative nurse assistant; communications; social-psychological aspects of long-term care; functional anatomy and physiology; functional significance of common health problems; cognitive loss and memory impairment; and specific restorative techniques. Each lesson consists of the following components: scope of unit; lesson objectives; information assignment; references; introduction; outline; summary and conclusion; interaction items; classroom/laboratory activities; and evaluation items with answer key. The module also contains sample chart notes written by a nurse and a glossary. (KC)

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Instructor Guide
50-5070-I

# RESTORATIVE NURSE ASSISTANT

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# RESTORATIVE NURSE ASSISTANT

## Instructor Guide

Produced by the Instructional Materials Laboratory
University of Missouri-Columbia
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# PREFACE

In July 1987 funds were provided by the Missouri Department of Elementary and Secondary Education for the development of curriculum materials covering the basic orientation and necessary skills which would enable the practicing Certified Nurse Assistant to be trained as a Restorative Nurse Assistant (RNA). The shift in emphasis from maintenance care to restorative care in the long-term care setting has created a need for trained paraprofessionals who are competent in the special knowledge and skills to assist in therapeutic rehabilitation as prescribed by the physical therapy, occupational therapy, and speech therapy consultants.

A special advisory committee met to establish the Missouri statewide occupational model for Restorative Nurse Assistant by identifying job-related competencies in this area. The competency list provided a framework from which the lesson plans in this curriculum guide were developed. A team of four writers with expertise in the therapies developed lesson plans within the recommended guidelines provided by the advisory committee.

Upon completion of the development phase, the curriculum guide underwent fieldtesting and technical review at sites throughout Missouri. Fieldtest/technical review evaluation results were then reviewed and necessary final revisions to the curriculum were implemented.

Although there are presently no federal or state regulations for Restorative Nurse Assistants, a great deal of discussion during the advisory committee meeting was focused on the philosophical aspects of such a training program. It was the consensus of those attending the meeting that the RNA should be viewed as an expanded role for the Certified Nurse Assistant. With this expanded role, which involves increased interaction with therapy consultants, more is required of the RNA in the areas of communication and monitoring responsibilities. Committee members also felt that it was important to emphasize the philosophy of rehabilitation as well as the concept of the RNA as a role model and resource person for all members of the staff (these points are covered in detail in Unit I, lessons 1 and 2, respectively). Additionally, the advisory committee proposed some specific recommendations that may be considered guidelines for implementing a training program for RNAs. Their recommendations are as follows:

**STATEMENT OF PHILOSOPHY:** It is the right of every individual to receive optimum health care delivered by trained personnel. Federal and state laws and regulations are adopted to insure quality care to residents of health care facilities. The Restorative Nurse Assistant acquires special knowledge, skills, and techniques in therapeutic rehabilitation as prescribed and suervised by licensed personnel. The resident's welfare is the legal and personal responsibility of the Restorative Nurse Assistant as well as the other members of the long-term health care team.

**PREREQUISITES FOR THE RNA COURSE:** The committee recommended that the RNA course should be offered to those individuals who qualify based on the following criteria:

- The individual should be a practicing CNA with at least six months experience after completion of the CNA program.
- The individual should be recommended by the director of nursing of the facility at which he/she is employed.
- The individual should have a high school diploma or GED.

**EDUCATIONAL PROGRAM:** A recommended program consists of the following:

- The program constitutes at least 30 hours of classroom-laboratory instruction.
- A minimum of 30 hours of clinical practice will be given each participant under the supervision of the facilitator and licensed therapist.
- Hours of clinical practice may vary with each student based on mastery learning.
- Evaluation includes written tests.

**TRAINING FACILITIES:** Recommended training sites include the following:

- Area Vocational-Technical Schools
- Comprehensive High Schools
- Community Colleges
- Selected four-year institutions
- Classes may be held in health care facilities, but must be administered through the above mentioned agencies.

**INSTRUCTOR QUALIFICATIONS:** The advisory committee recommended the following minimum requirements:

- The course may be facilitated by an RN (preferably a Certified Rehabilitation Nurse or Certified Gerontological Nurse). She/he may teach up to Unit VI (Specific Care Problems of the LTC Resident).
- Individual consultants (i.e., physical therapist, occupational therapist, speech therapist) should teach specific restorative procedures in their respective areas.

**TESTING PROCEDURE:** A recommended testing procedure is:

- There will be a written final exam consisting of 50 questions of which 80% must be answered correctly by the student.

- The practical exam will consist of a minimum of six skills, two from each discipline. Required skills will be:

    1. Draping the resident for treatment/procedures
    2. Range of motion exercises
    3. Transfer techniques
    4. Ambulation activities

## ACKNOWLEDGMENTS

We wish to thank the following individuals for their contributions in the development of these instructional materials.

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|---|---|
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## SUGGESTED HOURS FOR UNITS OF INSTRUCTION

| | |
|---|---|
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| Unit II - Communications | 2 hours |
| Unit III - Psychosocial Aspects of Long-Term Care | 2 hours |
| Unit IV - Functional Anatomy and Physiology | 2 hours |
| Unit V - Functional Significance of Common Health Problems | 4 hours |
| Unit VI - Cognitive Loss and Memory Impairment | 6 hours |
| Unit VII - Specific Restorative Techniques | 12 hours |
| Total Classroom/Laboratory Instruction | 30 hours |
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LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

SCOPE OF UNIT:

This unit defines rehabilitation and explains the philosophy of rehabilitation. It identifies the members of the health care team, including the restorative nurse assistant, and explains their roles. It describes the members of the physical therapy, occupational therapy, and speech therapy staffs with whom the RNA will work in the LTC setting. This unit also provides a review of nursing staff personnel. Functions of these various departments in helping residents to achieve their goals will be identified. The role of the RNA will be defined; and the ethical and legal responsibilities of the RNA and his/her supervisor will be explained.

INFORMATION TOPIC: I-1 OR DEMONSTRATION:

## DEFINITION AND PHILOSOPHY OF REHABILITATION AND THE HEALTH CARE TEAM

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Define rehabilitation.
3. Identify the philosophy of rehabilitation.
4. Name the members of the health care team referred to in this course.
5. Identify the roles of the members of the health care team.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Definition of Rehabilitation
2. TM 2: Philosophy of Rehabilitation
3. HO 1: The Health Care Team

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit I, Lesson Plan 2, "The Long-Term Health Care Team." Be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Ferguson, Diana. Physical Therapy Aide Student Manual. Austin: Center for Occupational Curriculum, University of Texas at Austin, 1982.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Taber, Clarence Wilbur. Taber's Cyclopedic Medical Dictionary. Philadelphia: F.A. Davis Company, Clayton L. Thomas (ed.), 1981.

INTRODUCTION:

In helping to restore an individual to health, it is important for everyone involved in the restorative process to understand each other and work together in assisting the resident to achieve maximum self-care and productiveness. To do this, we must understand what rehabilitation is and the philosophy we are trying to promote. In this lesson you will learn the definition and philosophy of rehabilitation. You will also build upon your knowledge of the health care team members and their roles, as defined in this course.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Diagnosis - the kind of disease or medical condition a person has

B. Goal - the desired end result; what one hopes to accomplish

C. Long-term care resident (LTC resident) - a person who, due to aging or illness, receives or requires care and services furnished by a facility (ICF or SNF), and who lives at the facility

D. Physical therapy (PT) - rehabilitation concerned with restoring function and prevention of disability; often involves the use of therapeutic agents like heat, cold, massage, and exercise

E. Rehabilitation - the process of restoring an individual to his/her maximum level of independence following an accident, injury, or illness to all or part of the body or mind

F. Restorative - returning or maintaining a resident to physical or mental health or consciousness

G. Speech therapy - the study and treatment of defects and disorders of the voice and of impairments of written or spoken communication

H. Occupational therapy (OT) - the use of work-related skills to treat or train the physically or emotionally ill

II. Definition and Philosophy of Rehabilitation (II-1)

A. Rehabilitation - the process of restoring an individual to his/her maximum level of independence following an accident, injury, or illness to all or part of the body (TM 1)

B. Philosophy of rehabilitation - in restoring an individual in LTC one must consider (TM 2):

1. Resident's physical condition

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2. Resident's emotional and mental condition throughout recovery

3. The importance of the resident performing self-care as independently as possible

4. The importance of education, as well as treatment, to the resident's recovery

5. The importance of all caregivers working together with the resident toward achieving goals

III. Members of the Health Care Team and Their Roles (HO 1)(II-2)

A. Long-term care resident and family - must always be the most important members of the team; resident's recovery depends on support and cooperation of family (II-3)

B. Resident's physician

1. Evaluates the resident's physical and mental condition

2. Based on his/her evaluation of the resident, makes a diagnosis

3. Directs the team by prescribing the resident's treatment and care

C. Nursing staff

1. Responsible for seeing that the physician's prescribed treatment and care for the resident are carried out

2. Assists others on the team in teaching the resident to perform the maximum level of self-care possible

3. Monitors and evaluates the resident's progress

D. Physical therapy, occupational therapy, and speech therapy

1. Responsible for following the prescribed treatment for the resident

2. Responsible for establishing and updating their own short-term and long-term goals for the resident throughout the restorative process

E. Activities director and social services

1. Assist resident in participating in meaningful work, leisure, and social activities.

2. Responsible for coordination of resident's involvement in the community (social, financial, psychological, spiritual) both in and out of LTC facility

F. Restorative nurse assistant - assists all members of the team, as specified by his/her supervisor, in meeting the resident's needs

NOTE: **Other members of the health care team including the administrator, dietary employees, and general housekeeping employees are important as well, however their roles will not be emphasized in this course.**

IV. Summary and Conclusion

A. Terms and definitions

B. Definition and philosophy of rehabilitation

C. Members of the health care team and their roles

In order to be a successful restorative nurse assistant you must first have an understanding of the definition and philosophy of rehabilitation. You must always remember that even though the long-term care resident is the most important member of the team, you are also a vital member. By understanding what each member's role is, you will be able to interact appropriately with other individuals on the team and effectively communicate your role as a restorative nurse assistant.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

INTERACTION ITEMS:

1. What do you think rehabilitation means?
2. Before working with a resident in long-term care, what things about that individual do you think are important to consider?
3. Who are the members of the health care team, and who is the most important member?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students role-play different members of the health care team while other members of the class try to identify them.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I: INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

EVALUATION ITEMS:

Match the terms listed below to correct definitions by writing the letter in the blank.

____ 1. Returning or maintaining a resident to physical or mental health or consciousness

____ 2. A person who, due to aging or illness, receives or requires care and the services furnished by a facility, and who lives at the facility

____ 3. The desired end result; what one hopes to accomplish

____ 4. The use of work-related skills to treat or train the physically or emotionally ill

____ 5. The process of restoring an individual to his/her maximum level of independence following an accident, injury, or illness to all or part of the body or mind

____ 6. Concerned with restoring function and prevention of disability; often involving the use of therapeutic agents like heat, cold, massage, and exercise

____ 7. The kind of disease or medical condition a person has

____ 8. The study and treatment of defects and disorders of the voice and of impairments of written or spoken communication

a. Occupational therapy

b. Goal

c. Rehabilitation

d. Long-term care resident

e. Speech therapy

f. Diagnosis

g. Restorative

h. Physical therapy

9. The following considerations: physical condition; emotional and mental condition; importance of performing self-care; education; and working together are all aspects of: (Circle the letter of the correct answer.)

   a. Definition of rehabilitation
   b. Goals of the LTC resident
   c. Philosophy of rehabilitation
   d. Responsibility of physician

10. Draw a diagram which represents the health care team and indicate the most important member.

Match the health care team member to his/her responsibility by writing the appropriate letter in the blank.

____11. Establishes and updates their own short-term and long-term goals throughout the restorative process

____12. Assists all members of the team as specified by his/her supervisor

____13. Responsible for coordination of the resident's involvement in the community

____14. Directs the team by prescribing the resident's treatment and care

____15. Sees that prescribed treatment and care for the resident is carried out

a. Nursing staff

b. Physical therapy, occupational therapy, speech therapy

c. Activities director and social services

d. Physician

e. Restorative nurse assistant

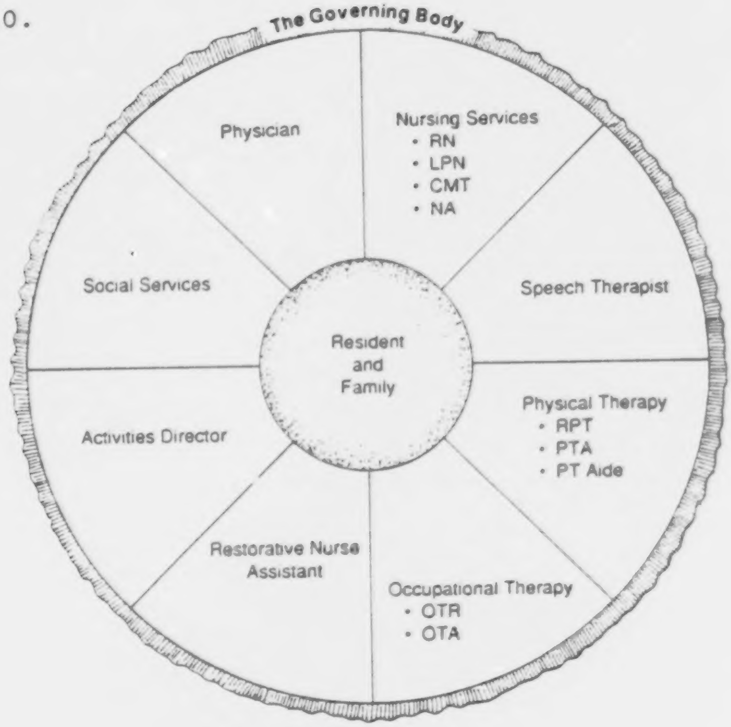
LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. g
2. c
3. b
4. a
5. c
6. h
7. f
8. e
9. c
10.


The Governing Body
Physician
Nursing Services
• RN
• LPN
• CMT
• NA
Social Services
Speech Therapist
Resident and Family
Activities Director
Physical Therapy
• RPT
• PTA
• PT Aide
Restorative Nurse Assistant
Occupational Therapy
• OTR
• OTA

The student should indicate that the resident is the most important member.

11. b
12. e
13. c
14. d
15. a

# Definition of Rehabilitation

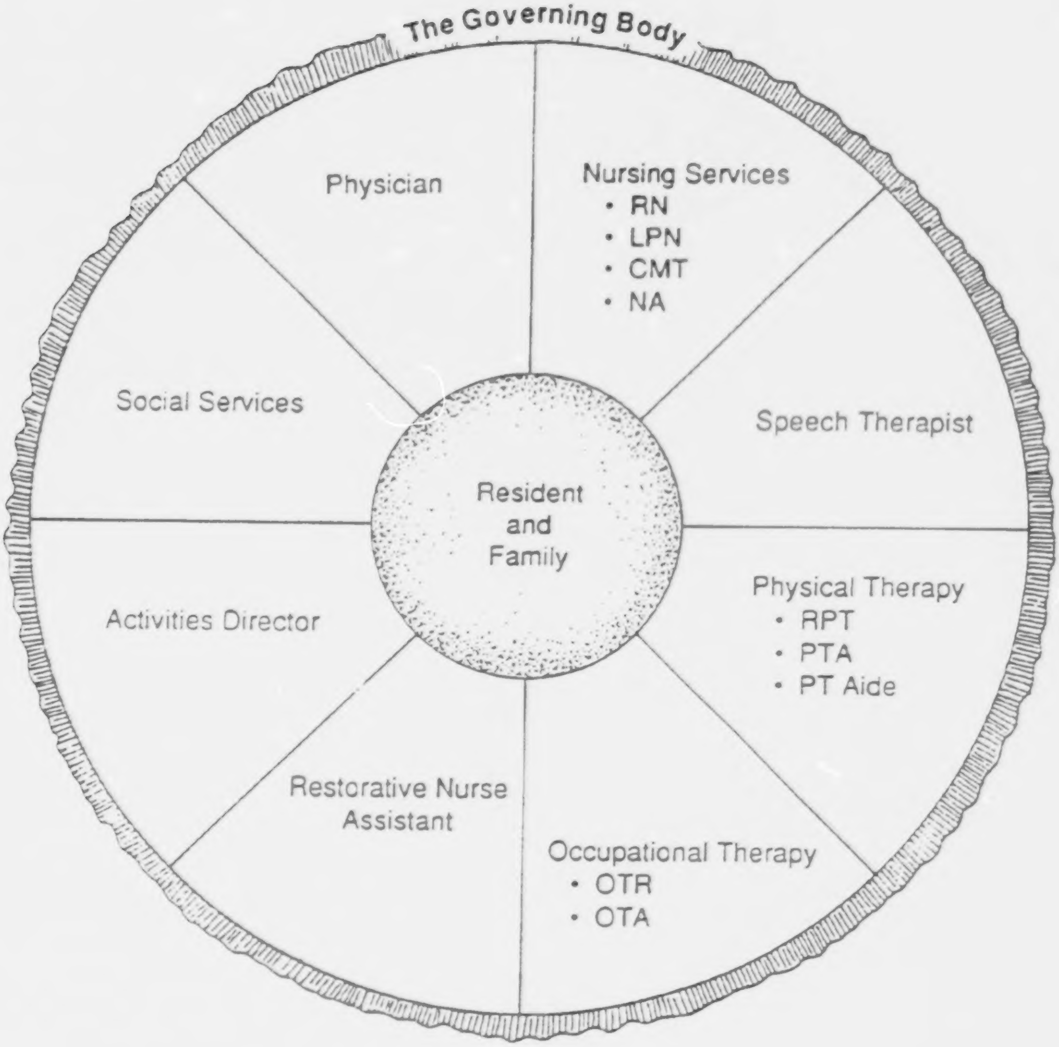
Rehabilitation is the process of restoring an individual to his/her maximum level of independence following an accident, injury, or illness to all or part of the body or mind.

# Philosophy of Rehabilitation

In restoring an individual in LTC one must consider:

1. The resident's physical condition
2. The resident's emotional and mental condition
3. The importance of the resident performing self-care as independently as possible
4. The importance of education, as well as treatment, to the resident's recovery
5. The importance of all caregivers working together with the resident toward achieving goals

# The Health Care Team


The Governing Body
Physician
Nursing Services
• RN
• LPN
• CMT
• NA
Speech Therapist
Physical Therapy
• RPT
• PTA
• PT Aide
Occupational Therapy
• OTR
• OTA
Restorative Nurse Assistant
Activities Director
Social Services
Resident and Family

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LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

SCOPE OF UNIT:

This unit defines rehabilitation and explains the philosophy of rehabilitation. It identifies the members of the health care team, including the restorative nurse assistant, and explains their roles. It describes the members of the physical therapy, occupational therapy, and speech therapy staffs with whom the RNA will work in the LTC setting. This unit also provides a review of nursing staff personnel. Functions of these various departments in helping residents to achieve their goals will be identified. The role of the RNA will be defined; and the ethical and legal responsibilities of the RNA and his/her supervisor will be explained.

INFORMATION TOPIC: I-2 OR DEMONSTRATION:

## MEMBERS AND FUNCTIONS OF THE THERAPIES AND NURSING STAFF AND THE ROLE OF THE RESTORATIVE NURSE ASSISTANT

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify staff members of physical therapy, occupational therapy, speech therapy, and nursing and their functions.
3. List goals of physical therapy, occupational therapy, speech therapy, and nursing in care of the LTC resident.
4. Identify two major shared goals of the health care team.
5. Define the role of the RNA.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: The Physical Therapist
2. TM 2: The Physical Therapist Assistant
3. TM 3: The Physical Therapy Aide
4. TM 4: The Occupational Therapist

5. TM 5: The Occupational Therapist Assistant

6. TM 6: The Speech Therapist

7. HO 1: The Role of the RNA

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit I, Lesson Plan 2, "The Long-Term Health Care Team." Be prepared to discuss the information regarding the nursing staff.

REFERENCES: (Instructor's Additional Information)

Ferguson, Diana. Physical Therapy Aide Student Manual. Austin: Center for Occupational Curriculum, University of Texas at Austin, 1982.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Taber, Clarence Wilbur. Taber's Cyclopedic Medical Dictionary. Philadelphia: F.A. Davis Company, Clayton L. Thomas (ed.), 1981.

Wilmore, Jack H. Training for Sport and Activity. Boston: Allyn and Bacon, Inc., 1982.

INTRODUCTION:

Through your training and work experiences as a nurse assistant, you already are aware of the functions and importance of the nursing staff in resident care. It is equally important that you are knowledgeable of other members of the health care team who are also directly involved with restorative care. By learning about the backgrounds, functions, and goals of physical therapy, occupational therapy, and speech therapy workers, you can develop a better understanding of your expanded role as a restorative nurse assistant.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Activities of daily living (ADL) - activities that are performed in one's life on a daily basis

B. Ambulation - the act of walking

C. Assistive device - an apparatus, machine, or object which is constructed to aid an individual in performing a specific function (i.e., eating, walking, and communicating)

D. Balance - the ability to have complete control of the body as it moves through space

E. Communication - the exchange and understanding of information accomplished by sending and receiving messages

F. Compensate - make up for a deficiency

G. Emotional - relating to one's feelings

H. Endurance - the ability to resist fatigue (can be specific to a particular muscle or generalized in terms of total body endurance)

I. Exercise - performed activity of the muscles, voluntary or otherwise

J. Mobility - ability to move

K. Physical - relating to the body and the functioning of the body

L. Restorative - returning/maintaining a resident to health or consciousness

M. Speech - verbal expression of one's thoughts

N. Strength - the maximum ability to apply or resist force

O. Therapeutic - having medicinal or healing qualities; a healing agent

P. Transfer - to move from one place to another

II. Members of Therapies and Nursing Staffs (II-1)

A. Physical therapy staff

1. Physical therapist (RPT) (TM 1)

   a. Education - bachelor's or master's degree from an American Physical Therapy Association accredited school

   b. Responsibilities

      1) Evaluate and re-evaluate residents.

      2) Design and implement treatment programs.

      3) Communicate with physician concerning treatment.

      4) Supervise PT assistant and PT aide.

      5) Keep updated progress notes concerning residents.

   c. Credentials - all 50 states, District of Columbia, and Puerto Rico require licensing; individual must pass an examination administered through the state or territory

2. Physical therapist assistant (TM 2)

   a. Education - graduate of a two-year associate degree program accredited by the American Physical Therapy Association

   b. Responsibilities

      1) Assist the physical therapist in evaluation and setting up treatment programs for residents.

      2) Carry out the treatment program designed by the physical therapist.

      3) Keep notes on resident responses to the treatment.

   c. Credentials - presently, only a few states have licensure of physical therapist assistants (Missouri does not)

3. Physical therapy aide (TM 3)

    a. Education - a class for PT aide and/or on-the-job training

    b. Responsibilities

        1) Assist the therapist and PT assistant in carrying out treatment.

        2) Transport residents to and from the department.

        3) Other functions vary from one facility to another (i.e., maintaining department equipment, and whirlpool aide).

    c. Credentials - no licensure required at present time

B. Occupational therapy staff (TM 4)

1. Occupational therapist (OTR)

    a. Education - bachelor's degree from American Occupational Therapy Association accredited school

    b. Responsibilities

        1) Evaluate and re-evaluate residents.

        2) Design and implement treatment programs.

        3) Communicate with physician concerning treatment.

        4) Supervise OT assistant.

        5) Keep updated progress notes concerning residents.

        6) Approve and countersign all notes written by OT assistant.

    c. Credentials

        1) In Missouri, must be registered with the American Occupational Therapy Association

        2) Licensed in 35 states by examination

2. Occupational therapist assistant (OTA) (TM 5)

    a. Education - graduate of a two-year associate degree program accredited by the American Occupational Therapy Association (AOTA)

    b. Complete an internship of at least two months.

    c. Responsibilities

        1) Assist the occupational therapist in evaluation and setting up treatment programs for residents.

        2) Carry out the treatment program designed by the occupational therapist.

        3) Keep notes on resident responses to the treatment.

    d. Credentials

        1) Must pass national COTA examination.

        2) No licensure in Missouri at present time.

C. Speech therapy - speech therapist (speech-language pathologist)

1. Education - master's degree from an accredited training program certified by the Board of Examiners of the American Speech and Hearing Association and an additional nine months of full-time professional work experience

2. Responsibilities

    a. Evaluate and re-evaluate residents.

    b. Design and implement treatment programs.

    c. Communicate with physician concerning treatment.

    d. Keep updated progress notes concerning residents.

3. Credentials

    a. Different requirements in different states

    b. Requirements for Missouri

1. Complete a master's degree or equivalent.

2. Complete 9 months of full-time or more months of part-time supervised employment as a speech-language pathologist.

3. Pass the examination for clinical competence administered by the American Speech-Language and Hearing Association.

4. Hold a certificate of clinical competence.

D. Nursing staff (general review)

1. RN - responsible for coordination and supervision of all resident care

2. LPN - works with RN in planning, assigning, and evaluating nursing care

3. CMT - prepares and administers selected medications

4. CNA - primary bedside caregiver under supervision of the charge nurse

III. Goals for Each Department (II-2, II-3)

A. Physical therapy helps LTC resident to:

1. Restore, maintain, or improve ADL's, including walking, transfers, and rolling.

2. Instruct in use of assistive devices or techniques necessary to safely ambulate and transfer.

3. Maintain, restore, or improve specific joint and overall mobility and balance.

4. Use prescribed therapeutic agents (i.e., heat, cold, exercise, ambulation, and massage) that help decrease pain, improve circulation, strengthen muscles, and increase endurance.

B. Occupational therapy helps LTC resident to:

1. Restore, maintain, or improve daily living skills such as eating, grooming, hygiene, toileting, and dressing.

2. Compensate for functional limitations by adapting the environment or use of special assistive devices.

3. Participate in meaningful work, leisure, and social activities.

4. Prevent further disability.

C. Speech therapy helps LTC resident to:

1. Restore or improve his/her level of communication.

2. If need be, establish alternative methods, other than speech, to communicate.

3. Use adaptive devices (i.e., electronic devices, communication boards, and spelling boards) to communicate.

4. Restore or improve ability to swallow.

D. Nursing staff helps LTC resident to:

1. Restore, maintain, or improve his/her ability to participate in ADL, including bowel and bladder retraining.

2. Follow through with prescribed treatments including medications, social activities, and therapy if necessary.

3. Reinforce a positive attitude toward self-care and to deal with fears regarding aging and disability.

4. Prevent skin breakdown and contractures through good body alignment and positioning.

E. It is the goal and responsibility of all members of the health care team to:

1. Assist the LTC resident in coping with the physical and emotional effects of long-term care/disability.

2. Insure the quality of life of each resident.

IV. The Role of the RNA (HO 1) (II-4)

A. Supervised by whomever his/her facility designates through institutional policy

B. Role model and resource person for all members of the

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staff, including consultants (i.e., PT, OT, and speech therapy)

C. Member of the health care team; reports any changes or observations regarding the resident to his/her supervisor

D. Advocate of the restorative process; assists resident in self-care

E. Responsible for the follow-up and maintenance of restorative plans established by members of the resident's health care team

F. Performs specific restorative procedures (i.e., feeding, ambulation, exercise, observation, and reporting)

V. Summary and Conclusion

A. Terms and definitions

B. Members of therapies and nursing staffs

C. Goals for each department

D. The role of the RNA

Before learning how to fill your role as the RNA, you must first have an understanding of the backgrounds and functions of the therapies, as well as a working knowledge of the nursing department. By assisting the other health care team members, their goals for the resident will become your goals as well.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

INTERACTION ITEMS:

1. What does restorative mean?
2. What do you think a physical therapist does? . . . occupational therapist? . . . speech therapist?
3. How many residents requiring treatment by one of the therapists have you have worked with?
4. What do you think your role as an RNA will be?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Invite an RN, PT, OT, and speech pathologist to answer questions from the class about their departments.
2. Discuss with the class how important the RNA will be in assisting the other members of the health care team in following through with restorative care.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

EVALUATION ITEMS:

Match the terms listed below to correct definitions below by writing the letter in the blank.

____ 1. The exchange of information accomplished by sending and receiving messages

____ 2. Ability to move

____ 3. Relating to the body and the functioning of the body

____ 4. The act of walking

____ 5. Activities that are performed in one's life on a daily basis

____ 6. Returning/maintaining a resident to health or consciousness

____ 7. Relating to one's feelings

____ 8. To move from one place to another

____ 9. An apparatus, machine, or object which is constructed to aid an individual in performing a specific function

____10. The ability to resist fatigue

____11. Performed activity of the muscles, voluntary or otherwise

____12. Make up for a deficiency

____13. Having medicinal or healing qualities; a healing agent

____14. The maximum ability to apply or resist force

a. Therapeutic

b. Assistive device

c. Endurance

d. Speech

e. Restorative

f. Emotional

g. Compensate

h. Strength

i. Mobility

j. Balance

k. ADL

l. Communication

m. Physical

n. Transfer

o. Ambulation

p. Exercise

**NOTE:** Items 15 & 16 appear on next page.

____15. The ability to have complete control of the body as it moves through space

Answers to items 15 & 16 appear on the previous page.

____16. Verbal expression of one's thoughts

17. It is the function of the speech, occupational, and physical therapists to: (Circle the letter of the best answer.)

   a. Evaluate and re-evaluate residents
   b. Supervise PT assistant and PT aide
   c. Design and implement treatment programs
   d. a and c above

18. It is the function of the PT and OT assistants to: (Circle the letter of the best answer.)

   a. Be responsible for all team members working together
   b. Keep notes on resident responses to treatment
   c. Transport residents to and from the department
   d. Prepare and administer selected medications

19. It is the function of the NA to: (Circle the letter of the best answer.)

   a. Plan, assign, and evaluate nursing care
   b. Communicate directly with physician concerning resident treatment
   c. Be primary bedside caregiver

Match each goal to its department by writing the letter in the blank.

____20. Instruct in use of assistive devices necessary to safely ambulate and transfer

____21. Participate in meaningful work, leisure, and social activities

____22. Maintain, restore, or improve specific joint and overall mobility and balance

____23. Restore or improve level of communication

a. Nursing

b. Occupational therapy

c. Speech therapy

d. Physical therapy

____24. Prevent skin breakdown and contractures through good body alignment

____25. Restore or improve ability to swallow

____26. Restore, maintain, or improve ADL including eating, toileting, and dressing

____27. Follow through with prescribed treatments including medications and social activities

a. Nursing

b. Occupational therapy

c. Speech therapy

d. Physical therapy

28. Name the two major shared goals of the health care team.

    a.

    b.

29. Briefly describe three of the six roles of the RNA as outlined in this lesson.

    a.

    b.

    c.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. l
2. i
3. m
4. o
5. k
6. e
7. f
8. n
9. b
10. c
11. p
12. g
13. a
14. h
15. j
16. d
17. d
18. b
19. c
20. d
21. b
22. d
23. c
24. a
25. c
26. b
27. a

28. Answers should include:
    a. Assist resident in coping with physical and emotional effects of LTC/disability
    b. Insure the quality of life of each resident

29. Answers should include three of the following:
    a. Supervised by the facility designee determined through institutional policy
    b. Role model and resource person
    c. Member of the health care team
    d. Advocate of the restorative process and assist resident in self-care
    e. Responsible for the follow-up and maintenance of restorative plans
    f. Performs specific restorative procedures

# The Physical Therapist

1. Education
   - Bachelor's or Master's degree from an American Physical Therapy Association accredited school

2. Responsibilities
   - Evaluate and re-evaluate residents
   - Design and implement treatment programs
   - Communicate with physician concerning treatment
   - Supervise PT assistant and PT aide
   - Keep updated progress notes concerning residents

3. Credentials
   - Must be licensed in all 50 states, District of Columbia, and Puerto Rico by examination administered through each state or territory

# The Physical Therapist Assistant

1. Education
   - Graduate of a two-year associate degree program accredited by the American Physical Therapy Association

2. Responsibilities
   - Assist the physical therapist in evaluation and setting up treatment programs for residents
   - Carry out the treatment program designed by the physical therapist
   - Keep notes on resident responses to the treatment

3. Credentials
   - At the present time only a few states have licensure of physical therapist assistants (Missouri does not)

# The Physical Therapy Aide

TM 3

1. Education
   - A class for PT aide and/or on-the-job training

2. Responsibilities
   - Assist the therapist and PT assistant in carrying out treatment
   - Transport residents to and from the department
   - Other functions vary from one facility to another (i.e. maintaining department equipment and whirlpool aide)

3. Credentials
   - No licensure required at present time

# The Occupational Therapist

1. Education
   - Bachelor's degree from an American Occupational Therapy Association accredited school

2. Responsibilities
   - Evaluate and re-evaluate residents
   - Design and implement treatment programs
   - Communicate with physician concerning treatment
   - Supervise OT assistant
   - Keep updated progress notes concerning residents
   - Approve and countersign all notes written by OT assistants

3. Credentials
   - In Missouri, must be registered with the American Occupational Therapy Association
   - Licensed in 35 states by examination

# The Occupational Therapist

## Assistant

1. Education
    - Graduate of a two-year associate degree program accredited by the American Occupational Therapy Association
    - Complete internship of at least 2 months

2. Responsibilities
    - Assist the occupational therapist in evaluation and setting up treatment programs for residents
    - Carry out the treatment program designed by the occupational therapist
    - Keep notes on resident responses to the treatment

3. Credentials
    - Must pass national COTA examination
    - No licensure in Missouri at present time

# The Speech Therapist

## (Speech-Language Pathologist)

1. Education
    - Master's degree from an accredited training program certified by the Board of Examiners of the American Speech and Hearing Association and an additional nine months of full-time professional work experience.

2. Responsibilities
    - Evaluate and re-evaluate residents
    - Design and implement treatment programs
    - Communicate with physician concerning treatment
    - Keep updated progress notes concerning residents

3. Credentials
    - Different requirements in different states
    - Requirements for Missouri:
        a. Complete a master's degree or equivalent
        b. Complete 9 months of full-time or more months of part-time supervised employment as a speech-language pathologist
        c. Pass the examination for clinical competence administered by the American Speech-Language and Hearing Association
        d. Hold a certificate of clinical competence

# The Role of the RNA

1. Supervised by the facility designee
2. A role model for other CNAs and resource person for all members of the staff including consultants.
3. A member of the health care team who reports changes or observations regarding the resident to his/her supervisor
4. An advocate of the restorative process; assists resident in self-care
5. Responsible for the follow-up and maintenance of restorative plans established by members of the resident's health care team
6. Performs specific restorative procedures (i.e., feeding, ambulation, exercise, observation, and reporting)

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

SCOPE OF UNIT:

This unit defines rehabilitation and explains the philosophy of rehabilitation. It identifies members of the health care team, including the restorative nurse assistant, and explains their roles. It describes the members of the physical therapy, occupational therapy, and speech therapy staffs with whom the RNA will work in the LTC setting. This unit also provides a review of nursing staff personnel. Functions of these various departments in helping residents to achieve their goals will be identified. The role of the RNA will be defined; and the ethical and legal responsibilities of the RNA and his/her supervisor will be explained.

INFORMATION TOPIC: I-3 OR DEMONSTRATION:

ETHICAL AND LEGAL RESPONSIBILITIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify ethical and legal responsibilities of the restorative nurse assistant.
3. Identify activities which would violate the ethical and legal rights of the resident.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Resident's Rights

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit I, Lesson Plan 3, "Ethical and Legal Responsibilities," including the handout regarding resident's rights, and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Schow, R.L., et al. Communication Disorders of the Aged: A Guide for Health Professionals. Baltimore: University Park Press, 1978.

INTRODUCTION:

As a restorative nurse assistant, you will be fulfilling a vital role on the rehabilitation team. During this course of study you will be learning a great deal about the rehabilitation process which will help you in fulfilling your role. In addition, you will need to know the extent of your role as related to your ethical and legal responsibilities. This knowledge is essential not only for protection of the resident's rights, but also for your own protection against a possible liability suit. This lesson identifies the duties you may and may not ethically and legally perform as an RNA.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Effectiveness - how well a treatment is working

   B. Ethical - working with accepted principles of right and wrong

   C. Legal - relating to the law

   D. Maintenance - keeping present function through specific drills, exercises, protocols, etc.

   E. Prognosis - projected amount of recovery expected

   F. Therapist/consultant - an individual who holds a license to practice as a rehabilitation professional (i.e., physical therapist, occupational therapist, and speech therapist)

   G. Treatment - using specific techniques with the intention of improving function

II. Therapy-Related Activities Which May be Performed by the RNA

   A. Provide maintenance therapy as specifically outlined by the licensed therapist. (II-1)

   B. Assist the resident with drills outlined by the therapist.

   C. Make objective chart notes regarding resident's performance during maintenance or drill therapy.

   D. Communicate resident's performance verbally to the therapist.

   E. Use special knowledge to remind others of special precautions to take with certain residents as directed by the therapist (i.e., resident should be sitting erect during meals, etc.).

III. Therapy-Related Activities Which May Not be Performed by the RNA

A. **DO NOT** communicate verbally, or in writing, resident's progress or performance status to physicians, other therapists, or family members. (II-2)

B. **DO NOT** violate confidentiality by discussing residents outside the LTC facility.

C. **DO NOT** change therapy plans that have been established by the therapist; however, should resident experience pain or frustration, activity should stop and the therapist informed.

D. **DO NOT** teach others to perform maintenance therapy.

E. **DO NOT** answer questions from staff, family, resident, or physician regarding prognosis or projected length of treatment.

F. **DO NOT** prescribe treatment.

G. **DO NOT** make judgments about effectiveness of treatment.

IV. General Ethical and Legal Considerations

A. Remember that you are not a therapist, consultant, therapist assistant, or licensed nurse, and therefore cannot legally perform those duties that are assigned to them.

B. Become familiar with resident's rights and protect them at all times. (HO 1)

1. Considerate and respectful care
2. Complete and current information concerning his/her diagnosis, treatment, and prognosis
3. Information necessary to give informed consent prior to the start of any procedure and/or treatment
4. Refuse treatment to the extent permitted by law, and to be informed of the consequences
5. Consideration of his/her privacy
6. Confidentiality of communication and records of treatment
7. Expect caregivers to make a reasonable response to a request for service

8. Expect reasonable continuity of care

9. Examine and receive an explanation of her/his bill

10. Know what rules and regulations apply to his/her conduct as a resident receiving restorative care

C. Know the difference between maintenance and treatment (refer to terms and definitions).

D. Become familiar with the policies and procedures at your facility and your specific job description in relation to those policies and procedures.

V. Summary and Conclusion

A. Terms and definitions

B. Therapy-related activities which may be performed by the RNA

C. Therapy-related activities which may not be performed by the RNA

D. General ethical and legal considerations

Throughout your work day at the LTC facility you will be faced with many decisions regarding interactions with residents, staff, family, physicians, etc. By remembering to perform only those duties as specifically stated in your job description, by respecting resident's rights, and by following the specific recommendations made by the therapists/consultants, you will be able to fulfill your role as RNA in a legal, ethical manner.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

INTERACTION ITEMS:

1. What types of duties may the RNA ethically and legally perform?

2. What types of activities would constitute legal or ethical violations on the part of the RNA?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Discuss what the RNA should do in the following situations:

1. The resident asks, "Will I get better?"

2. The resident's husband asks, "Will my wife ever walk again?"

3. You see a friend at the grocery store who asks how Mrs. Smith (a resident in your LTC facility) is doing in her speech therapy.

4. You are doing range of motion exercises on Mr. Brown's arm and he screams out in pain.

5. Mr. Williams just entered your LTC facility from another state. You wonder if he might benefit from occupational therapy to help him feed himself.

6. You help Mrs. Wright with her speech drill, but she gets only 10% correct. You think the drill is too difficult.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 1. The RNA may provide maintenance therapy as outlined by the licensed therapist.

_____ 2. The RNA may provide information to the physician about a resident's progress in therapy as long as the physician specifically asks.

_____ 3. Only a licensed therapist may make chart notes.

_____ 4. Only a licensed therapist may change a resident's therapy plan.

_____ 5. If the RNA has overheard the therapist tell the resident that he/she will probably be in therapy for two more months, the RNA may pass that information on to the family.

_____ 6. The RNA may show a family member how to do range of motion exercises with the resident who goes home for the weekend.

_____ 7. If a resident experiences pain during a drill, the RNA should continue the drill until the session is over and inform the therapist about it the next day.

_____ 8. If a resident with a severe hearing loss is receiving instructions from a nursing assistant standing behind his/her wheelchair, and is having obvious difficulty understanding what is being said, it would be within the RNA's role to ask the nursing assistant to face the resident.

_____ 9. The RNA should not prescribe treatment.

_____ 10. Ethical and legal violations by a health care professional could result in a law suit.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT I : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. T
2. F
3. F
4. T
5. F
6. F
7. F
8. T
9. T
10. T
11. d
12. a
13. e
14. g
15. f
16. b
17. c

# Resident's Rights

The resident has the right to:

1. Considerate and respectful care
2. Complete and current information concerning his/her diagnosis, treatment, and prognosis
3. Information necessary to give informed consent prior to the start of any procedure and/or treatment
4. Refuse treatment to the extent permitted by law, and to be informed of the consequences
5. Consideration of his/her privacy
6. Confidentiality of communication and records of treatment
7. Expect caregivers to make a reasonable response to a request for service
8. Expect reasonable continuity of care
9. Examine and receive an explanation of her/his bill
10. Know what rules and regulations apply to his/her conduct as a resident receiving restorative care

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

SCOPE OF UNIT:

This unit discusses active listening and responding. More specifically, methods of effective communication with coworkers and residents will be reviewed.

INFORMATION TOPIC: II-1 OR DEMONSTRATION:

INTERPERSONAL COMMUNICATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson with correct definitions.
2. Explain the concept of multiple channels as an effective communication tool.
3. Identify factors causing a loss of information between speaker and listener.
4. Differentiate between a factual (objective) statement and a statement of inference (subjective).
5. List three methods of managing conflict.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Differences Between Factual and Inferential Statements

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit I, Lesson Plan 5, "Communication Skills." Be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Klinzig, Dennis and Dene Klinzig. Communication for Allied Health Professionals. Dubuque, IA: Wm. Brown Publishers, 1985.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1987.

Purtillo, Ruth. Health Professional/Patient Interaction. Philadelphia: W.B. Saunders Co., 1985.

INTRODUCTION:

As a restorative nurse assistant, you will be communicating throughout the day with residents, family members, and coworkers. Just because two people are talking, however, does not necessarily mean that communication is occurring. Effective communication enables an exchange of ideas, information, and feelings.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Inferential (subjective) information - includes observer's judgments and opinions

   B. Factual (objective) information - observable and documented without bias or judgments from the observer

   C. Sympathy - identifying with another person's feelings and emotions

   D. Empathy - insightful, nonjudgmental awareness of a person's feelings and emotions

II. Communication in Restorative Care

   A. Relay information that accurately reflects the course of treatment.

      1. Always use multiple (more than one) channels (i.e., verbal and written or written with diagrams).
      (II-1)

      2. Observations - looking and thinking about what you are seeing and what it means

      3. Written observations document change. Examples:

         a. "Able to stand for longer periods of time."

         b. "Can button two more buttons."

         c. "Can reach forward further than yesterday."

      4. Relay what action was taken to prevent possible problems.

      5. Relay changes in behavior.

   B. Avoid confusing factual and inferential statements.
   (II-2)

      1. Factual (objective) information - observable and documented without bias or judgment from the observer

2. Inferential (subjective) information - includes the observer's opinions or judgments; inferential statements should be preceded by phrases such as "I believe," or "it appears to me."

III. Loss of Information

A. Occurs when speaker's and listener's values and perceptions differ, causing listener to disregard parts of the message he/she considers unimportant.

B. Two-way communication improves information sharing and problem solving.

C. Avoid open-ended questions when seeking clarification.

IV. Dealing Effectively with Conflict (II-3)

A. Conflict is an inevitable and potentially beneficial occurrence.

B. Communication is the key to managing conflict.

C. Three methods of conflict management:

1. Avoidance - stay away from the source of conflict (person or situation)

2. Mediation - seek assistance from an unbiased third party who can defuse the hurt/anger on both sides as well as offer several objective, workable solutions

3. Mutual problem solving - both sides work together to resolve the conflict and come up with solutions that are mutually acceptable

V. Summary and Conclusion

A. Terms and definitions

B. Communication in restorative care

C. Loss of information

D. Dealing effectively with conflict

Maintaining an open communication channel with coworkers is a shared responsibility for both speaker and listener. With continued practice, active listening along with the ability to relate information with clarity will become second nature.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

INTERACTION ITEMS:

1. What are the differences between sympathy and empathy?
2. How can multiple channels be used to relay information to the other nurse assistants about a particular resident's adapted feeding utensils? . . . about the correct method of ambulation or transfer assistance?
3. Give an example of an inferential statement to describe today's weather. Now give an example of an objective or factual statement.
4. How can conflict be beneficial?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Role-play one or more of the following situations in which communications have broken down:

1. Mr. P. continues to be positioned in his wheelchair with a sheepskin pad under his buttocks instead of his prescribed custom seat cushion, despite instructions to the nurses on correct pressure relief for this resident.
2. The occupational therapy consultant does not seem to remember your verbal observations about Mr. B.'s new-found ability to consistently use a drinking straw, or at least she didn't acknowledge your report.
3. The restorative aide has just met Mrs. R.'s daughter for the first time. The daughter comments, "The people at the hospital said that Mother will never walk again or be able to use her right hand. Is that true? I think she will get better." The RNA says . . .

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

EVALUATION ITEMS:

Match the terms listed below to correct definitions by writing the letter in the blank.

_____ 1. Insightful awareness of person's feelings

_____ 2. Includes observer's judgments and opinions

_____ 3. Observations that can be documented without bias or judgments

_____ 4. Identifying with another's feelings or emotions

a. Subjective

b. Objective

c. Sympathy

d. Empathy

5. One example of the use of multiple channels of communication would be: (Circle the letter of the correct answer.)

   a. Talking on the phone and reporting in the care plan meeting
   b. Writing a note in the medical chart and reporting in the care plan meeting
   c. Posting a picture display to show the other nurse assistants the correct adaptive dressing technique for a resident
   d. Explaining to the physical therapy consultant why a resident has not received treatment

6. Loss of information often occurs because: (Circle the letter of the correct answer.)

   a. Speaker's and listener's values and perceptions are the same
   b. The listener disregards information he/she judges to be unimportant
   c. The speaker uses too many factual statements
   d. The listener uses too many factual statements

Identify each statement (items 7-11) listed below as a factual (write "F") or inferential (write "I") statement.

7. _____ She seems to be depressed this afternoon.

8. _____ He cried when we talked about his arm sling.

9. ______ Mr. J.'s standing tolerance has improved from 10 minutes to 15 minutes.

10. ______ He enjoyed his meal more when using the adapted utensils.

11. ______ Mrs. H.'s problem is that she likes to be in charge all the time.

12. List three methods of managing conflict:

a.

b.

c.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. b
4. c
5. b
6. b
7. I
8. F
9. F
10. I
11. I
12. a. Avoidance
    b. Mediation
    c. Mutual problem solving

HO 1

# Differences between Factual and Inferential Statements

| Factual (Objective) Statements | Inferential (Subjective) Statements |
|---|---|
| 1. May be made only after observation | 1. May be made at any time |
| 2. Are limited to what has been observed | 2. Go beyond what has been observed |
| 3. May be made only be the observer | 3. May be made by anyone |
| 4. May only be about the past or the present | 4. May be about any time--past, present, or future |
| 5. Approach certainty | 5. Involve varying degrees of probability |
| 6. Information can be verified | 6. Has no basis of fact |

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

SCOPE OF UNIT:

This unit discusses active listening and responding. More specifically, methods of effective communication with coworkers and residents will be reviewed.

INFORMATION TOPIC: II-2 OR DEMONSTRATION:

THERAPEUTIC COMMUNICATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List three active listening skills.
2. Identify types of feedback response given to the speaker by the listener.
3. Identify instances of effective communication between the RNA and members of the professional staff.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Listening is the Key
2. HO 2: Communication for Specific Behavior Patterns

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit I, Lesson Plan 5, "Communication Skills." Be prepared to discuss Handout 1: How to Be a Good Listener."

REFERENCES: (Instructor's Additional Information)

Berger, Milton. Working with People Called Patients. New York: Brunner/Mazel Publishers, 1977.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Purtillo, Ruth. Health Professional/Patient Interaction. Philadelphia: W.B. Saunders Co., 1985.

INTRODUCTION:

Whether one is helping an older adult to walk or assisting the resident in a feeding task, that particular moment can be viewed as an opportunity to communicate and establish a good therapeutic relationship between RNA and the resident. Active listening and responding with understanding on the part of the restorative nurse assistant are essential skills, and necessary to the welfare of the resident. Of equal importance is meaningful communication between the RNA and other members of the health care team.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

OUTLINE: (Key Points)

I. Effective Communication with the Resident

  A. Utilize active listening skills. (HO 1)

    1. Put speaker at ease.

    2. Avoid distractions.

    3. Be patient.

  B. Adopt a style of communication that matches the resident's behavior. (HO 2)

  C. Provide positive verbal/nonverbal feedback responses to the speaker indicating your understanding of the speaker's point of view.

    1. Restate the message in an attempt to clarify.

    2. Respond frequently.

    3. Nonverbals may include nodding of the head, shoulder shrug, smile, frown, silence, or touch. (II-1)

II. Effective Communication with the Professional Staff

  A. Listen to the therapists and other staff members when discussing the residents.

  B. Make a note of:

    1. Changes in resident program

    2. Changes in resident health or diagnosis

    3. Changes in resident environment

    4. Social changes or emotional changes that may affect resident performance (i.e., family situation; upcoming anniversaries that might be painful for the resident to remember; a recent outing)

  C. If outlined program is unclear or resident's condition is unclear, ask questions before proceeding.

D. Use your notes to assist you when you complete recordkeeping and to refresh your memory regarding any changes.

E. Always report any changes in resident to supervisor or therapist **IMMEDIATELY.**

F. Should a conflict with another staff member arise, report it to your supervisor and seek resolution. Conflicts between staff members adversely affect resident care. (II-2)

III. Summary and Conclusion

A. Effective communication with the resident

B. Effective communication with the professional staff

As a restorative nurse assistant, you will be required to communicate with residents having different levels of understanding and different needs. Developing a relationship and maintaining effective communications with the residents and your coworkers is important. Effective communication is a valuable skill which takes time to develop, however once acquired, it can be one of your most valued skills.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

INTERACTION ITEMS:

1. What might be an example of negative nonverbal feedback response?
2. What would you do if you had a disagreement with another staff member concerning a resident's program?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students refer to HO 1 and discuss communications and the therapeutic relationship depicted in this particular situation. What changes could be made?
2. Divide the class into pairs with one person role-playing the therapist and the other the RNA. Have the therapist discuss a fictional resident, with the RNA noting any changes in program, resident health, etc. Determine by review how well the RNA listened. Reverse the roles.
3. Explain and discuss facilities documentation forms.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : COMMUNICATIONS

EVALUATION ITEMS:

1. Active listening skills include: (Circle the letter of the correct answer.)

   a. Making the speaker comfortable
   b. Giving the resident a limited time to speak
   c. Doodling on your notepad while listening to the speaker
   d. Interrupting to give the speaker guidance

Match each of the following examples of nonverbal communication to the best description of how it could be interpreted by the observer.

____ 2. Yawning

____ 3. Establishing eye contact and nodding

____ 4. Drumming fingers on the tabletop

____ 5. Wrinkling your brow

a. "I understand."

b. "I am bored."

c. "Please clarify -- I don't understand."

d. "Please hurry and finish talking."

Identify instances of effective communication between the RNA and members of the professional staff by writing "E" in the blank. If the example describes ineffective communication, write "I" in the blank.

____ 6. The RNA always makes a conscious effort to listen to the therapist when discussing the resident.

____ 7. The RNA does not find it necessary to take note of a resident's emotional changes which affect his/her performance.

____ 8. The RNA proceeds without asking questions when the outlined program is not really clear, thinking that she will figure it out as she goes along.

____ 9. The resident exhibits a change in behavior which the RNA reports immediately to his supervisor.

____10. The RNA has a conflict with another staff member and asks the resident what to do about it.

LESSON PLAN: 2

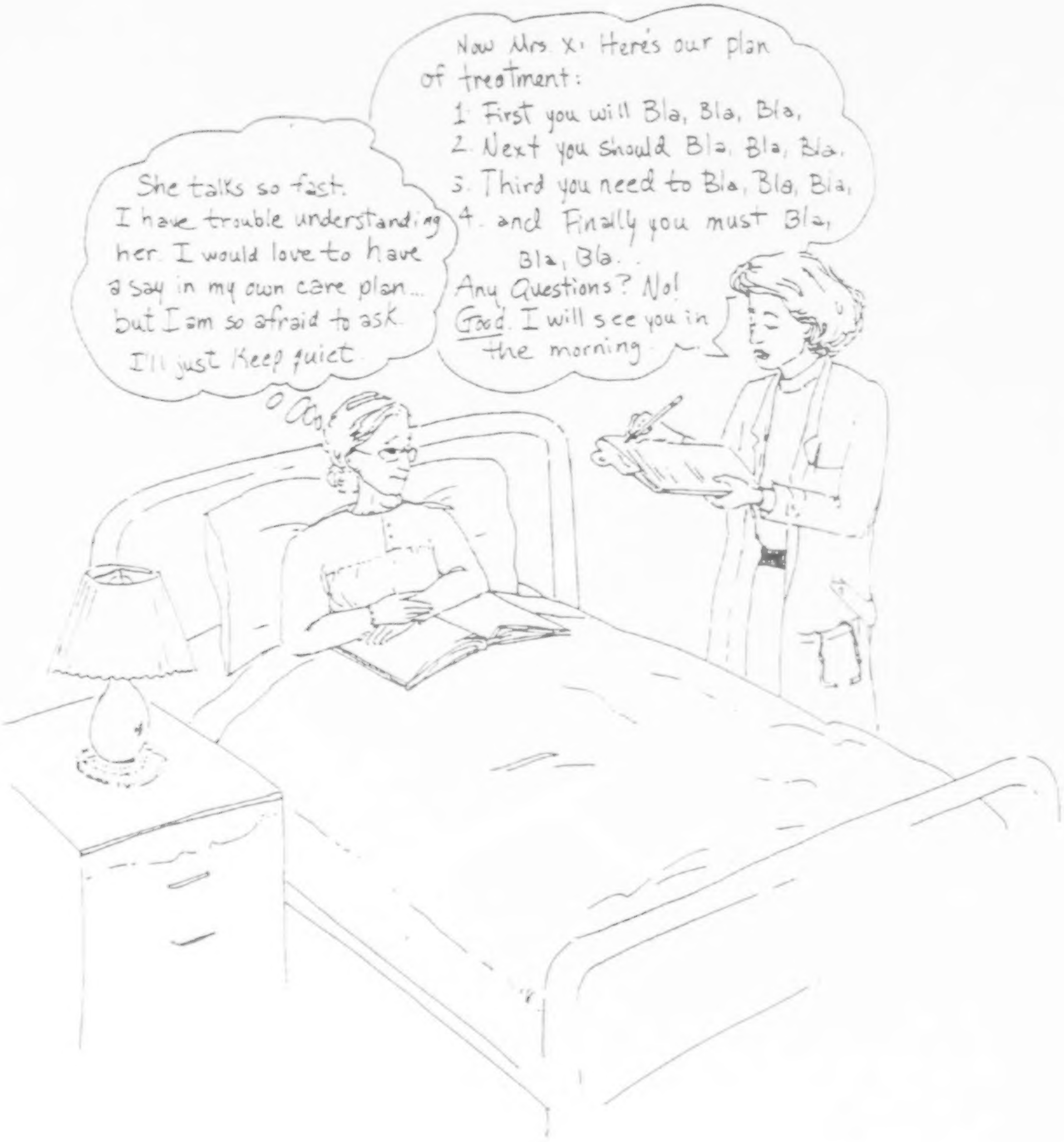
COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT II : INTRODUCTION TO RESTORATIVE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. a
2. b
3. a
4. d
5. c
6. E
7. I
8. I
9. E
10. I

# Listening is the Key


She talks so fast. I have trouble understanding her. I would love to have a say in my own care plan... but I am so afraid to ask. I'll just Keep quiet.
Now Mrs. X: Here's our plan of treatment: 1. First you will Bla, Bla, Bla, 2. Next you should Bla, Bla, Bla. 3. Third you need to Bla, Bla, Bla, 4. and Finally you must Bla, Bla, Bla.. Any Questions? No! Good. I will see you in the morning.

HO 2

# Communication
## for Specific Behavior Patterns

A. The withdrawn resident
  1. Needs security, consistency, motivation
  2. Specific suggestions
    a. Use simple concrete language
    b. Reduce length of sentences
    c. Give attention to certain words for emphasis
    d. Keep conversation concrete and realistic

B. The depressed resident
  1. Needs self-confidence and self-esteem
  2. Specific suggestions
    a. Do not force decisions
    b. Avoid long conversation, as resident tires easily
    c. Expect difficulty in concentration
    d. Repeat questions and statements
    e. Expect periods of silence

C. The overactive resident
  1. Needs to decrease talkativeness
  2. Needs to avoid irritating others
  3. Specific suggestions
    a. Do not argue
    b. Elation can quickly turn into irritation
    c. Sarcastic remarks are best met with mild humor; sarcasm is based on insecurity
    d. Verbal aggression can be an outlet for hostility; limitations may be necessary

D. The anxious, fearful resident
  1. Needs to develop wholesome attitudes
  2. Specific suggestions
    a. Be matter-of-fact, firm but considerate
    b. Do not focus attention on symptoms
    c. Develop skill in conversation; learn resident's interests
    d. Use positive suggestion; avoid saying what not to do

E. The "manipulative" resident
  1. Needs help in forming relationships
  2. Specific suggestions
    a. Be consistent in what all personnel say
    b. Avoid being caught in conversation "traps"
    c. Use scrupulous honesty in what is told resident
    d. Expect distortion by resident of what is being said

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

SCOPE OF UNIT:

This unit will highlight the psychological and social components of providing restorative care to the elderly person. Psychosocial needs will be discussed, as well as barriers to need fulfillment such as personality traits, poor coping skills, lack of motivation, and age-related physical changes. The mourning process will also be discussed.

INFORMATION TOPIC: III-1 OR DEMONSTRATION:

## PSYCHOSOCIAL NEEDS: ADAPTING TO LIFE CHANGES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List three psychosocial needs of the long-term care resident.
3. For each psychosocial need, identify two ways the RNA can assist the resident in need fulfillment.
4. Identify three personality traits found to be best suited for coping with the stress of aging.
5. List three factors which would contribute to the motivation of a long-term care resident.
6. List three methods of coping that may be exhibited by the resident which create barriers to fulfillment of psychosocial needs.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit II, Lesson Plan 9, "The Aging Process and Related Health Problems," and Lesson Plan 10, "Emotional Needs." Be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Kiernat, Jean. "Environment: The Hidden Modality." Physical and Occupational Therapy in Geriatrics Vol. 2 (1), Fall 1982.

Lewis, C.B. Aging: The Health Care Challenge. F.A. Davis, 1985.

Lewis, S.C. Providing for the Older Adult. Slack, Incorporated, 1983.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

INTRODUCTION:

Rehabilitation with any age group involves more than physical treatment. Recognizing the effects of psychological and social aging can be the key to understanding the behaviors and actions of the LTC resident. In this lesson, you will learn the many factors that influence a person's attitudes, motivation, and ability to cope with daily life situations.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Emotional lability - tendency to cry or laugh inappropriately, usually due to brain damage

   B. Motivation - factors that influence one's choice of activity or type of behavior

   C. Self-concept - how a person views herself/himself

II. Psychosocial Needs and How the Restorative Nurse Assistant Helps Meet Them

   A. The need to maintain a sense of identity

      1. Preserve resident's identity by actively listening as he/she reminisces to recall earlier times.

      2. Call resident by her/his name.

      3. Make sure resident wears street clothes whenever appropriate.

      4. Provide a mirror for resident's room.

   B. The need to continue meaningful activity - "connectedness"

      1. Encourage resident to maintain social ties with other people which result in quality interactions.

      2. Stress the importance of therapy goals (i.e., gait training or strengthening exercises needed to resume participation in favorite activities).

      3. Become aware of resident's likes and dislikes, interests, and values. Such information can be useful to the therapy consultants in planning treatment. (II-1)

   C. The need for the ability to exert control over his/her environment

      1. Provide opportunities for decision-making (i.e., choice of treatment time, meal selection, what clothing to wear, group vs. one-to-one treatment).

2. Encourage ADLs (dressing, undressing, grooming, etc.).

3. Show respect for the resident and recognize his/her accomplishments. (II-2)

4. Use clear charts, symbols, or graphs to allow resident to see gains or improvements in therapy.

III. Barriers to Fulfillment of Psychosocial Needs

A. When needs are not met, adjustment to normal life changes is difficult.

B. Chronic illness or progressive disease

1. Anxiety emerges when physical problems are diagnosed.

2. Progress fluctuates; good and bad days are unpredictable. (II-3)

C. Age-related changes - interpretation and understanding of surroundings becomes more difficult

1. Slowing of responses

2. Physical abilities decline

3. Increased vulnerability to disease

D. Poor coping skills

1. Extreme defensiveness - viewing surroundings as threatening, dangerous, and something to be overcome

2. The "jokester" - constant joking and kidding is used to deny his/her unhappiness

3. Withdrawal - choosing to remain in his/her own small world; may be labeled senile

4. Dependency - no effort to cope; wants to give up all responsibilities for self

5. Anger - hostile, blames others for own limitations (II-4)

D. Personality profile

1. Personality may change after disease or illness.

a. Exaggerated emotions - example: extreme feeling of well-being is commonly associated with multiple sclerosis

b. Emotional lability - resident may think she/he is "going crazy"

c. Passivity - inactive; being submissive to action taken upon them

d. Impulsivity - commonly seen when stroke has affected the right side of the brain

2. Personality characteristics that cope well with the changes of aging

a. Flexibility - ability to adapt to new situations

b. Mature - using a constructive approach to life

c. Simplistic - limited role involvement, one sees life as uncomplicated

E. Motivation - refers to factors that influence the choice of activity or type of behavior

1. It is important to identify all of the factors that go into making a decision; some factors are:

a. Self-concept

b. Personality

c. Attitudes of caregivers

d. Personal wants and needs

2. Ways to improve motivation

a. Provide successful experiences that increase the resident's sense of control and accomplishment.

b. Give feedback in both word and action.

c. Tap into resident's likes and dislikes, wants, and desires.

d. Provide meaningful, quality personal interactions. (II-5)

e. Foster support by including family members whenever possible.

## IV. Summary and Conclusion

A. Terms and definitions

B. Psychosocial needs and how the restorative nurse assistant helps meet them

C. Barriers to fulfillment of psychosocial needs

During this lesson you have learned about several intrinsic factors which can either enhance or slow down the restorative process. Most importantly, you must remember that each resident is truly unique and is being affected by many life changes. Your understanding of his/her particular set of circumstances is important so that you can develop an effective therapeutic relationship.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

INTERACTION ITEMS:

1. How can a resident's interests or values be used to make therapy sessions more meaningful or enjoyable?
2. What are some ways in which we show respect for the resident?
3. What is an example of a disease or condition in which progress fluctuates?
4. How might you deal with a resident who is always angry and hostile?
5. What is meant by quality interactions? Give an example.

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III: PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

EVALUATION ITEMS:

Match the terms listed below to correct definitions by writing the letter in the blank.

_____ 1. Factors that influence one's choice of activity or type of behavior

_____ 2. How a person views herself/himself

_____ 3. Tendency to cry or laugh inappropriately, usually due to brain damage

a. Emotional lability

b. Motivation

c. Self-concept

4. List three psychosocial needs of the long-term care resident and list at least two ways the RNA can assist the resident in need fulfillment.

a.

b.

c.

For each of the following, write "T" if the statement is true, or "F" if the statement is false.

____ 5. A resident may have difficulty participating in meaningful activity due to poor eyesight or hearing.

____ 6. The extremely defensive person jokes to cover up his or her unhappiness.

____ 7. A resident may cope with life by giving up all responsibility for her own well-being.

____ 8. Emotional lability is commonly seen in residents who have had strokes or other neurological problems.

____ 9. The person with a flexible personality profile is less likely to adapt to the effects of aging.

____ 10. A resident may sense more control over his environment if he is shown respect and recognition for his accomplishments.

11. Which three of the following personality traits are found to be most effective in coping with the stress of aging? (Circle the letters of **ALL THREE** correct answers.)

a. Flexibility
b. Stubbornness
c. Self-destructive
d. Mature
e. Simplistic
f. Complex

12. List three factors which contribute to the motivation of a long-term care resident.

a.

b.

c.

13. List three methods of coping that create barriers to fullfillment of psychosocial needs.

a.

b.

c.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

ANSWERS TO EVALUATION ITEMS:

1. b
2. c
3. a
4. a. The need to maintain a sense of identity
   (The student may list any two of the following:)
   1. Preserve resident's identity by actively listening as he/she reminisces to recall earlier times.
   2. Call resident by her/his name.
   3. Make sure resident wears street clothes whenever appropriate.
   4. Provide a mirror for resident's room.

   b. The need to continue meaningful activity - "connectedness"
   (The student may list any two of the following:)
   1. Encourage resident to maintain social ties with other people which result in quality interactions.
   2. Stress the importance of therapy goals (i.e., gait training or strengthening exercises needed to resume participation in favorite activities).
   3. Become aware of resident's likes and dislikes, interests, and values. Such information can be useful to the therapy consultants in planning treatment.

   c. The need for the ability to exert control over his/her environment
   (The student may list any two of the following:)
   1. Provide opportunities for decision-making (i.e., choice of treatment time, meal selection, what clothing to wear, group vs. one-to-one treatment).
   2. Encourage ADL's (dressing, undressing, grooming, etc.)
   3. Show respect for the resident and recognize his/her accomplishments.
   4. Use clear charts, symbols, or graphs to allow resident to see gains or improvements in therapy.
5. T
6. F
7. T
8. T
9. F
10. T
11. a, d, and e

12. The student may list any three of the following:
    a. Self-concept
    b. Personality
    c. Attitudes of caregivers
    d. Personal wants and needs
13. The student may list any three of the following:
    a. Extreme defensiveness - viewing surroundings as threatening, dangerous, and something to be overcome
    b. The "jokester" - constant joking and kidding
    c. Withdrawal
    d. Dependency
    e. Anger

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

SCOPE OF UNIT:

This unit will highlight the psychological and social components of providing restorative care to the elderly person. Psychosocial needs will be discussed, as well as barriers to need fulfillment such as personality traits, poor coping skills, lack of motivation, and age-related physical changes. The mourning process will also be discussed.

INFORMATION TOPIC: III-2 OR DEMONSTRATION:

PSYCHOSOCIAL NEEDS: EXTERNAL INFLUENCES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define personal space.
2. Identify ways the RNA can respect personal space and territorial needs.
3. Identify spiritual needs of the long-term care resident.
4. Identify aspects of the RNS's role in assisting a resident in meeting his/her spiritual needs.
5. List two reasons why the LTC resident may face financial problems.
6. List two social roles which may be lost by the resident as a result of catastrophic illness or injury.
7. Identify society's attitudes toward the disabled and/or elderly.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

American Heart Association publications:
#50-005-A - Do It Yourself Again
#50-026-A - Up and Around

Both publications are available from:
American Heart Association, Missouri Affiliate
P.O. Box Q
Columbia, MO 65205
(314) 443-1511

Bengston, Vera L. and David Haber. "Sociological Perspectives on Aging." In D. Woodruff and J. Birren (eds.) Aging: Scientific Perspectives and Social Issues. Monterey: Brooks/Cole Publishing Co., 1983.

Dowling, R.J. "Federal Health Insurance for the Elderly." In D.S. Beasley and G.A. Davis (eds.) Aging: Communication Processes and Disorders. New York: Grune and Stratton, 1981.

INTRODUCTION:

When an individual loses functions such as sight, hearing, speech, or the ability to walk, dramatic changes occur in his or her life. These changes can affect family members and friends as well. This lesson will focus on some of the external social and psychological aspects which can affect the elderly. The resident's physical environment, economic factors, and the impact of spiritual needs will be discussed.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Personal space - invisible space which surrounds each of us and serves as a buffer between the self and others

   B. Territorial behavior - the need for clearly defined personal space; gives privacy and allows for control

II. Physical Environment

   A. Consider the residents's personal space when initiating and maintaining positive relationships.

      1. Approach resident slowly.

      2. Allow him/her the opportunity to indicate when a comfortable distance has been met. (II-1)

      3. Obtain resident's consent before moving into her/his personal space.

      4. Be aware of resident's visual acuity, hearing, and speed of response.

   B. Territorial needs refer to the need for clearly defined and personalized territory; provides privacy and allows for control of one's surroundings. (II-2)

      1. Assist resident to feel "at home" in therapy space to reduce stress and discomfort and improve performance.

      2. Encourage resident to personalize treatment area.

      3. Failure to recognize this need may trigger anxious, defensive behavior.

   C. Barrier-free surroundings (II-3)

      1. Ease in negotiating space when considering problems with mobility, vision, and sensation.

      2. Involvement in daily activities should be gratifying and reassuring rather than anxiety producing.

III. Spiritual Needs

- A. Residents' reaction to disability
    1. May be searching for a reason to continue living after suffering a disability.
    2. May be insisting that "God will make me well again."
- B. Responsibilities of the RNA
    1. Be a good listener; allow resident to talk about her/his feelings.
    2. Don't let your own beliefs get in the way. Show respect for resident's beliefs even if they conflict with your own.
    3. Help the resident obtain spiritual guidance if requested, through books, church friends, and/or clergy.
    4. Respect resident's privacy when he/she is obtaining spiritual guidance, praying, or performing other religious rituals. (II-4)
    5. Religious beliefs can be powerful, motivating forces. Recognize this fact and respond in a positive and accepting manner toward resident's references to his/her beliefs, while maintaining a realistic outlook for the resident's rehabilitation potential.

IV. Economic and Social Changes

- A. Financial difficulties
    1. High cost of long-term health care and insurance premiums
    2. Reduced Medicare and Social Security benefits
    3. Longer life expectancy
    4. New economic status
- B. Loss of social roles
    1. Financial provider/head of household
    2. Parent
    3. Spouse
    4. Community club member/activities

(II-5)

C. Society's concept of elderly and/or disabled

   1. Activities are limited

   2. Society's understanding of various handicapping conditions is limited

   3. Needs of the elderly are often ignored and services cut back due to lack of funding.

(II-6)

V. Summary and Conclusion

   A. Terms and definitions

   B. Physical environment

   C. Spiritual needs

   D. Economic and social changes

In this lesson we have discussed a variety of external factors which affect a resident's rehabilitation process. Some external factors are beyond the resident's control and beyond your control as a restorative nurse assistant. However, there are ways in which you can help the resident cope with his/her life changes through manipulation of the physical environment, and by maintaining a caring attitude toward the resident, his/her beliefs, and his/her needs.

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LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

INTERACTION ITEMS:

1. How do you know when you are invading someone's personal space?

2. How do you personally exhibit territorial behavior at work and at home?

3. How did you feel the last time you were lost, looking for a friend's house in a new neighborhood, looking for that new store in the mall, or finding a meeting room in a large building?

4. How can the RNA show respect for a resident's spiritual beliefs?

5. How might disabled residents lose the roles they previously filled both in society and in their family?

6. What do you think is society's concept of the disabled or elderly individual?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

EVALUATION ITEMS:

1. The term personal space refers to: (Circle the letter of the correct answer.)

   a. The resident's favorite chair in the activity room
   b. The resident's bathroom
   c. The place in the family that was vacated by the resident when he/she went to live in the LTC facility
   d. The invisible space which surrounds individuals and serves as a buffer between the self and others

2. As an RNA, you show respect and understanding of the resident's need for personal space by: (Circle the letter of the correct answer.)

   a. Giving your favorite resident a gift
   b. Ignoring a resident's request for more time in therapy
   c. Obtaining consent from the resident before coming too close to him/her
   d. Keeping the therapy area neat and clean

3. All of the following are ways to fulfill territorial needs in a LTC setting EXCEPT: (Circle the letter of the appropriate answer.)

   a. Allowing the resident to choose his/her own seat in the dining room at lunch
   b. Conducting therapy sessions in a different corner of the lounge area each day
   c. Helping the resident place personal objects on shelves and tables in his/her room
   d. When possible, allowing the resident to choose the room or space for his/her therapy session.

4. List two factors which may contribute to financial problems for the LTC resident

   a.

   b.

5. List two social roles that the LTC resident may lose as a result of catastrophic illness or injury.

   a.

   b.

For each of the following, write "T" if the statement is true, or "F" if the statement is false.

_____ 6. Generally, activities for elderly or disabled individuals are limited in today's society.

_____ 7. Society understands the problems of the disabled and is quick to appropriate funds for programs to serve their needs.

_____ 8. If a resident begins to discuss his/her religious beliefs, you should gently discourage it.

_____ 9. Try to avoid being judgmental when a resident discusses religious beliefs.

_____ 10. It is the family's responsibility to ask clergy to visit. The RNA has no part in obtaining spiritual guidance for a resident.

_____ 11. Religious beliefs can be powerful motivating forces in the rehabilitation process.

_____ 12. The resident should be allowed privacy when performing religious rituals such as praying.

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LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III: PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

ANSWERS TO EVALUATION ITEMS:

1. d
2. c
3. b
4. The student may list any two of the following:
    a. High cost of long-term health care and insurance premiums
    b. Reduced Medicare and Social Security benefits
    c. Longer life expectancy
    d. New economic status
5. The student may list any two of the following:
    a. Financial provider/head of household
    b. Parent
    c. Spouse
    d. Club member/activities
6. T
7. F
8. F
9. T
10. F
11. T
12. T

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

SCOPE OF UNIT:

This unit will highlight the psychological and social components of providing restorative care to the elderly person. Psychosocial needs will be discussed, as well as barriers to need fulfillment such as personality traits, poor coping skills, lack of motivation, and age-related physical changes. The mourning process will also be discussed.

INFORMATION TOPIC: III-3 OR DEMONSTRATION:

## THE MOURNING PROCESS AND THE RESPONSE OF THE RNA
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify the five stages of mourning and match them with their characteristics.
3. List the five stages of mourning in the order in which they usually occur.
4. Identify the appropriate response of the RNA to the resident who is experiencing a stage of mourning.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit II, Lesson Plan 13, "Death and Dying." Be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Kübler-Ross, Elisabeth. On Death and Dying. New York: McMillan Publishing Co., 1969.

Martin, James A. Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri Columbia, 1987.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Rando, Therese A. Grief, Dying and Death. Champaign, IL: Research Press Company, 1984.

INTRODUCTION:

In order to assist the resident who is experiencing a disability and is in need of rehabilitation, we must first understand the five stages of mourning (and sometimes dying) experienced by the resident. We are all unique individuals, therefore the length or severity of each stage will differ from resident to resident. In this lesson you will learn to identify the five stages of mourning and the order in which they generally occur. You will also become familiar with your role and beneficial responses that will assist the resident as he/she goes through these predictable stages.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Disability - the loss of or lack of ability to perform mental or physical tasks which one can normally do (as a result of injury or disease)

   B. Denial - the refusal to admit or acknowledge that something exists (i.e., a disability or disease)

   C. Mourning - normal grief which can be caused by the onset of an injury, disease or death of a loved one; reaction to loss

   D. Sympathy - having common feelings with or sharing the feelings of a resident

   E. Empathy - understanding the feelings of others without sharing them

II. Five Stages of Mourning (Loss)

   NOTE: **These characteristics are very similar for the resident experiencing loss through death as well as the resident experiencing loss due to disability.**

   A. Shock - emotional rather than physical

      1. Usually occurs immediately following onset of injury or illness in which disability is confimed by physician

      2. Often does not last long before progressing to next stage

   B. Denial

      1. Characterized by reactions such as " . . . this isn't really happening to me," or "I'm not really sick . . ."

      2. Closely related to shock stage

      3. Sometimes resistant to treatment during this stage due to refusal to acknowledge disability

C. Reality

   1. Finally accepts that disability exists and functions are impaired

   2. More accepting of treatment but still in somewhat of a "daze"

D. Anger

   1. Characterized by " . . . why me?" attitude and moodiness

   2. Resident often exhibits sudden, seemingly unprovoked, and angry outbursts

   3. Anger often directed toward family, God (if religious), and caregivers

E. Acceptance

   1. Characterized by increased motivation and cooperation with treatment and caregivers

   2. Even after this final stage is reached, it is not unusual for a resident to revert back to a previous stage.

   3. Resident may demonstrate frustration if progress and rehabilitation is slow. (II-1)

**NOTE: It is important to remember that the resident's family also experiences these stages and that their support may change periodically.**

III. The RNA's Response to the Ill or Disabled Resident

   A. Sympathy - having common feelings with or sharing the feelings of a resident

      1. A reaction of sympathy from the RNA would tend to prolong the condition or problem.

      2. Sympathetic responses tend to support attention-getting behavior and in some cases can actually promote illness and slow the resident's recovery.

   B. Empathy - understanding of how the resident feels(II-2)

      1. A positive understanding of how the resident feels

      2. Remembering that in order for the resident to

improve, he/she must carry out the procedure as directed.

C. Therapeutic approach of the RNA (II-3)

1. Encourage - even though the resident may feel he/she can't do it.

2. Understand that in order for the resident to succeed in his/her directed program, he/she must perform as much of the procedure as possible, with the least amount of assistance.

3. Get to know the resident and her/his likes and dislikes, however be consistent in your approach to all residents.

4. Avoid sympathizing and concentrate on genuinely caring for the resident; rather than just meeting her/his needs.

5. Be mindful of resident rights and report any changes in speech, behavior, or performance to your supervisor immediately.

IV. Summary and Conclusion

A. Terms and definitions

B. Five stages of mourning (loss)

C. The RNA's response to the ill or disabled resident

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOSOCIAL ASPECTS OF LONG-TERM CARE

INTERACTION ITEMS:

1. As an RNA, which of the five stages of mourning would you find most difficult to deal with in a resident? Why?

2. What is an example of an empathetic response you might give to a resident?

3. Why are social relationships with residents discouraged?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide the class into pairs. One student will be a resident and one the RNA. Have the resident act out the behavior of a particular stage of mourning, and have the RNA respond in an appropriate way.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III: PSYCHOLOGICAL AND SOCIAL ASPECTS OF LONG-TERM CARE

EVALUATION ITEMS:

Match the terms listed below to correct definitions by writing the correct letter in the blank.

____ 1. Normal grief following a loss

____ 2. Understanding the feelings of others without sharing them

____ 3. The refusal to admit or acknowledge that something exists

____ 4. The loss of ability to perform tasks which one can normally do

a. Denial

b. Mourning

c. Empathy

d. Disability

Match the characteristic associated with a stage of mourning to the correct stage by writing the letter in the blank.

____ 5. Increased motivation and cooperation with treatment and RNA

____ 6. Accepts that disability exists, however still somewhat in a "daze"

____ 7. Usually occurs immediately following onset of illness or disability

____ 8. "I'm not really sick . . ." refusal to acknowledge disability

____ 9. Moodiness and sudden seemingly unprovoked outbursts

a. Reality

b. Shock

c. Anger

d. Acceptance

e. Denial

10. List the five stages of mourning in the order in which they will most likely occur.

a.

b.

c.

d.

e.

11. Which stage of grief does the resident's family often experience?

For each of the following statements concerning THERAPEUTIC APPROACH TO THE RESIDENT, write "T" if the statement is true, or "F" if it is false.

____ 12. It is appropriate to encourage dependency in the resident.

____ 13. It is wise to avoid personal conversation with the resident. Your interactions should be "strictly business."

____ 14. You may hug and kiss favorite residents as rewards for good performance.

____ 15. The RNA should be efficient and caring toward all residents.

____ 16. It is acceptable for the RNA not to report that a resident is incontinent because the resident said he/she would be embarassed for anyone else to know.

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LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT III : PSYCHOLOGICAL AND SOCIAL ASPECTS OF LONG-TERM CARE

ANSWERS TO EVALUATION ITEMS:

1. b
2. c
3. a
4. d
5. d
6. c
7. b
8. e
9. c
10. a. Shock
    b. Denial
    c. Reality
    d. Anger
    e. Acceptance
11. All of the stages
12. F
13. F
14. F
15. T
16. F

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

SCOPE OF UNIT:

This unit covers aspects of anatomy and physiology of the long-term care resident which impact directly on function and the restorative process. Body systems covered in this unit include the skeletal system, the muscular system, the nervous system, and the sensory system.

INFORMATION TOPIC: IV-1 OR DEMONSTRATION:

## SKELETAL SYSTEM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Match skeletal structures of the body with their functions or characteristics.
3. List four types of moveable joints and give one example of each.
4. Identify skeletal malformations which can affect mobility given characteristics of each.
5. List three types of skeletal malformations which could affect speech.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Types of Joints
2. HO 2: Skeletal Malformations Caused by Injury
3. HO 3: Skeletal Structures Affecting Production of Speech
4. A skeleton or several diagrams of the skeletal structures

## INFORMATIONAL ASSIGNMENT: (Student)

## REFERENCES: (Instructor's Additional Information)

Benson, Harold J. and Stanley E. Gunstream. Anatomy and Physiology Laboratory Textbook. Dubuque, IA: William G. Brown Company Publishers, 1978.

Ferguson, Diana. Physical Therapy Aide Student Manual. Austin: Center for Occupational Curriculum, University of Texas at Austin, 1982.

Johns, Donnell F. Surgical and Prosthetic Management of Neurogenic Velopharyngeal Incompetency in Dysarthria. In JD.F. Johns (ed.) Clinical Management of Neurogenic Communicative Disorders. Boston: Little, Brown, and Co., 1985.

Kahane, Joel C. Anatomic and Physiologic Changes in the Aging Peripheral Speech Mechanism. In D.S. Beasley and G.A. Davis (eds.) Aging: Communication Processes and Disorders. New York: Grune and Stratton, Inc., 1981.

Sicher, Harry. Oral Anatomy. St. Louis: The C.V. Mosby Co., 1965.

Zemlin, W.R. Speech and Hearing Science Anatomy and Physiology. Englewood Cliffs: Prentice-Hall, Inc., 1988.

## INTRODUCTION:

The human body is a marvelous machine. In your training and experience as an NA, you have had an overview of the body systems. As an RNA, you will now need some additional and more specific information about the skeletal system, its structure, and how skeletal malformations figure into the restorative process.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Anatomy - the study of the structure of the body

   B. Arthritis - inflammation of a joint, usually causing pain

   C. Articulation - the movements of speech organs used in producing a particular speech sound which cause interruption and modification of air stream necessary to produce speech

   D. Bone fracture - any break of a bone

   E. Cartilage - tough, strong tissue; found in nose, ears, and at the ends of bones

   F. Endentulous - without teeth

   G. Hard palate - roof of the mouth

   H. Joint - place where two bones meet

   I. Ligament - sheet of tough tissue that holds bones together at the joints

   J. Mandible - lower jaw bone

   K. Maxilla - upper jaw bone

   L. Osteoporosis - loss of minerals from bone

   M. Pelvic girdle - includes hip bones and attachments for leg bones

   N. Sprain - injury to a ligament

   O. Temporomandibular joint - connects the upper and lower jaw

   P. Vertebral discs - discs of the spinal column down the middle of the back

II. Skeletal Structures of the Body and Their Characteristics

   A. Bones - 206 in the body; functions are: (II-1)

      1. Give form and shape to the body.

2. Protect the delicate internal organs, brain and spinal cord.

3. Act as levers (joints).

4. When muscle is attached to bone, gives the body motion and movement.

B. Joints - three types (HO 1) (II-2)

1. Immovable - maximum protection from injury; does not allow movement

    a. Joints of the skull

    b. Some joints of the pelvis

2. Partially movable - provides protection; allows limited mobility

    a. Where the ribs attach to the sternum

    b. The vertebrae of the body

3. Movable - allow for maximum mobility but minimal protection of the bone (HO 1)

    a. Hinge joint - allows for bending in one direction like a hinge on a door; includes knee, elbow, and finger

    b. Pivot joint - allows for rotation like unscrewing or screwing the lid of a jar; includes the head on the first cervical vertebrae which allows for rotating (turning) the head

    c. Ball and socket joint - allows movement in all directions, like a circle; includes shoulder and hip joints

    d. Gliding joint - allows for gliding motion only; includes the vertebrae, small bones of the wrist and ankle

C. Cartilage - tough, flexible tissue

1. Provides support

2. Acts as a cushion for the hard portion of the bone

D. Ligament - tough, inflexible tissue

1. Holds the bones together at the joints

2. Surrounds the synovial membrane which lubricates the surfaces of the bones much like oiling the hinge of a door

III. Skeletal Malformations Affecting Rehabilitation or Mobility (II-3)

A. Osteoporosis - loss of minerals of the bone

B. Arthritis - refers to many different diseases involving inflammation of the joints and usually pain and/or deformity - includes, but is not limited to:

1. Osteoarthritis - often called degenerative joint disease; most common type of arthritis

2. Rheumatoid arthritis - most crippling and causes multiple deformities

3. Gout - usually involves, but is not limited to, inflammation of the great toe

4. Bursitis - inflammation specifically of the sac surrounding the structures that make up the joint; rarely a direct cause of deformity

NOTE: More information about arthritis is included in Unit V, Lesson 1

C. Malformations caused by injury (HO 2)

1. Sprain - injury to a ligament which usually causes swelling and pain

2. Dislocation - usually of the hip or shoulder; involves a disruption of the joint which results in the bones being in an abnormal position

3. Fracture - a broken bone; which is either simple or compound

a. Simple (closed) fractures are of several types including:

(1) Complete - most common; results in two or more separate fragments of the bone

(2) Incomplete or greenstick - splitting or splintering of the bone

b. Compound (open) fractures involve the skin being broken as well as the bone

IV. Skeletal Malformations Affecting Production of Speech (HO 3)

- A. Damage to skeletal structures affecting respiration (II-4)
    1. Thorax - the chest; encased by the rib cage; must be flexible during breathing and speech processes
    2. Vertebral discs/spinal column - aid in posture during respiration and speech
    3. Pelvic girdle - positioning important for maximum efficiency of breathing during speech activities
- B. Damage to skeletal structures affecting articulation (II-5)
    1. Teeth - missing teeth or endentulous condition can lead to problems with articulation and intelligibility (formation of speech sounds that can be understood)
    2. Mandible - contributes to formation of lower oral cavity; affects resonance
    3. Maxilla - contributes to formation of entire oral cavity; important for proper resonance
    4. Hard palate - forms roof of the mouth; important for resonance; changes in shape or holes in palate affect vocal tone
    5. Temporomandibular joint - only movable bone of the face; important for adequate oral opening during speech

V. Summary and Conclusion

- A. Terms and definitions
- B. Skeletal structures of the body and their characteristics
- C. Skeletal malformations affecting rehabilitation or mobility
- D. Skeletal malformations affecting production of speech

The bones, joints, ligaments, and their related problems will be a major factor in your role as an RNA. Know them well and you will be able to successfully interact with therapists and residents. In the next lesson, you will see how the muscles affect movement of these bones and joints we have just learned.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

INTERACTION ITEMS:

1. How many bones in the body can you name?
2. What is a joint? How many can you identify?
3. What are some skeletal related diseases or problems a restorative nurse assistant might encounter?
4. What two skeletal structures discussed in class affect respiration?
5. What five skeletal structures discussed in class affect articulation?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide the class into pairs and take turns doing the following:
    a. Identify and try to palpate the major bones in each extremity including the femur, tibia, and fibula in the leg and the humerus, radius, and ulna in the arm.
    b. Identify the major joints of the body and list the bones involved in each and the type of joint it is.
    c. Identify and palpate one cervical vertebra, one thoracic vertebra, and one lumbar vertebra.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the letter in the blank.

____ 1. Inflammation of a joint, usually causing pain

____ 2. The study of the structure of the body

____ 3. The place where two bones meet

____ 4. Sheet of tough tissue that holds bones together at the joints

____ 5. Tough, strong tissue found in the nose, ears, and the ends of the bones

____ 6. Discs of the spinal column down the middle of the back

____ 7. Lower jaw bone

____ 8. Includes hip bones and attachments for leg bones

____ 9. Without teeth

____10. Loss of minerals from bone

____11. Injury to a ligament

____12. Movements of speech organs causing modification of air stream necessary to produce a particular speech sound

____13. Any break of a bone

____14. Roof of the mouth

____15. Connects the upper and lower jaw

____16. Upper jaw bone

a. Anatomy

b. Joint

c. Cartilage

d. Ligament

e. Arthritis

f. Sprain

g. Vertebral discs

h. Mandible

i. Articulation

j. Osteoporosis

k. Endentulous

l. Bone fracture

m. Maxilla

n. Temporomandibular joint

o. Hard palate

p. Pelvic girdle

Match the following skeletal structures with their functions or characteristics by writing the appropriate letter in the blank.

____17. Joints of the skull

____18. Allows for maximum mobility but minimal protection of the bone

____19. Gives form and shape to the body

____20. Surrounds the synovial fluid which lubricates the surfaces of the bones

____21. Acts as a cushion for the hard portion of the bone

____22. Where the ribs of the body attach to the sternum

a. Bone

b. Immovable joint

c. Partially moveable joint

d. Moveable joint

e. Cartilage

f. Ligament

23. List the four types of moveable joints and give one example of each.

a. Type:

Example:

b. Type:

Example:

c. Type:

Example:

d. Type:

Example:

Match the following skeletal problems to characteristics of each by writing the appropriate letter in the correct blank.

____24. Most crippling arthritis; can cause multiple deformities

____25. A broken bone, which is either simple or compound

____26. Loss of minerals of the bones

____27. Usually of the hip or shoulder; involves a disruption of the joint which results in the bones being in an abnormal position

____28. Usually involves, but is not limited to inflammation of the great toe

____29. Injury to a ligament which usually causes pain and swelling

____30. Involves breaking both the bone and skin

____31. Often called degenerative joint disease

____32. Inflammation of the sac surrounding the structures that make up the joint

____33. Most common of which is complete, involving two or more bone fragments

a. Sprain

b. Gout

c. Fracture

d. Osteoarthritis

e. Rheumatoid arthritis

f. Compound fracture

g. Bursitis

h. Simple fracture

i. Dislocation

j. Osteoporosis

34. List two general types of skeletal malformations which could affect speech.

    a.

    b.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

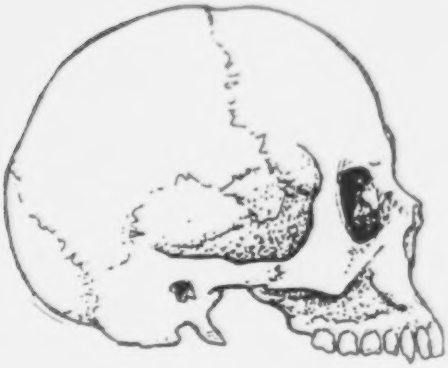
UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

ANSWERS TO EVALUATION ITEMS:

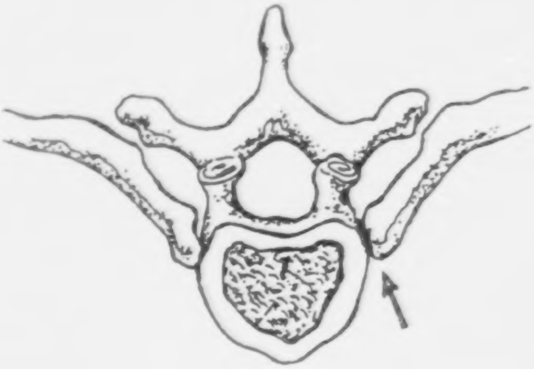
1. e
2. a
3. b
4. d
5. c
6. g
7. h
8. p
9. k
10. j
11. f
12. i
13. l
14. o
15. n
16. m
17. b
18. d
19. a
20. f
21. e
22. c
23. a. Hinge - (example) knee, elbow, or finger
    b. Pivot - (example) head on the first cervical vertebrae
    c. Ball and socket - (example) shoulder or hip
    d. Gliding - (example) vertebrae, small bones of wrist/ankle
24. e
25. c
26. j
27. i
28. b
29. a
30. f
31. d
32. g
33. h
34. a. Damage to skeletal structures affecting respiration
    b. Damage to skeletal structures affecting articulation

# Types of Joints

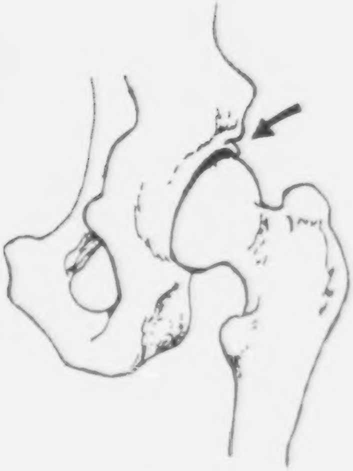
**Immovable**



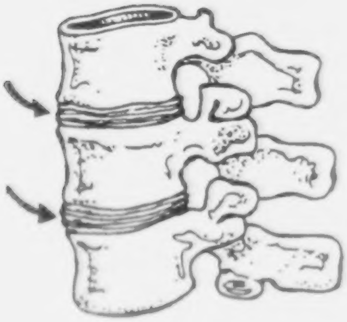
**Partially Movable**



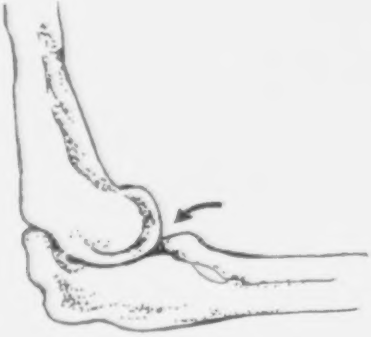
**Movable**



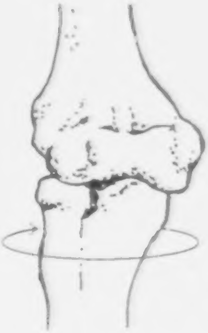
Ball and Socket



Gliding



Hinge

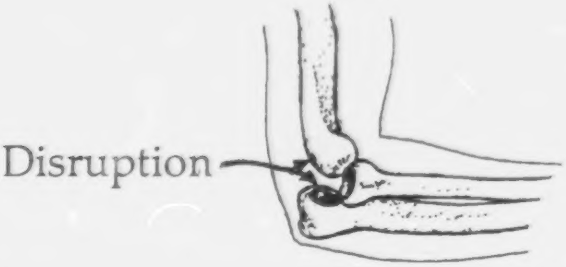


Pivot

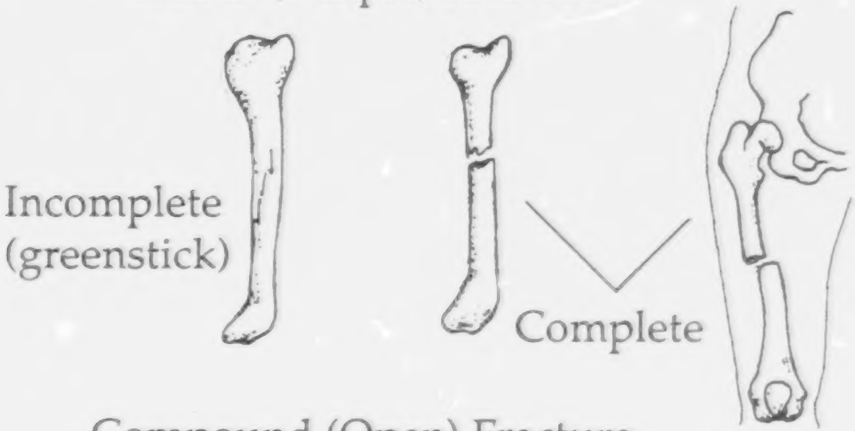
# Skeletal Malformations

## Caused by Injury

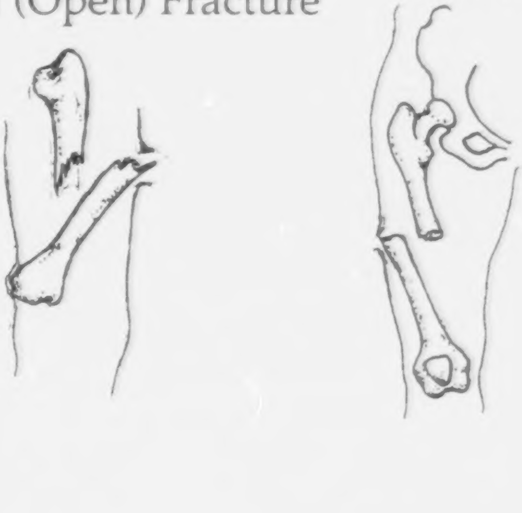
Dislocation


Disruption

Closed (Simple) Fractures

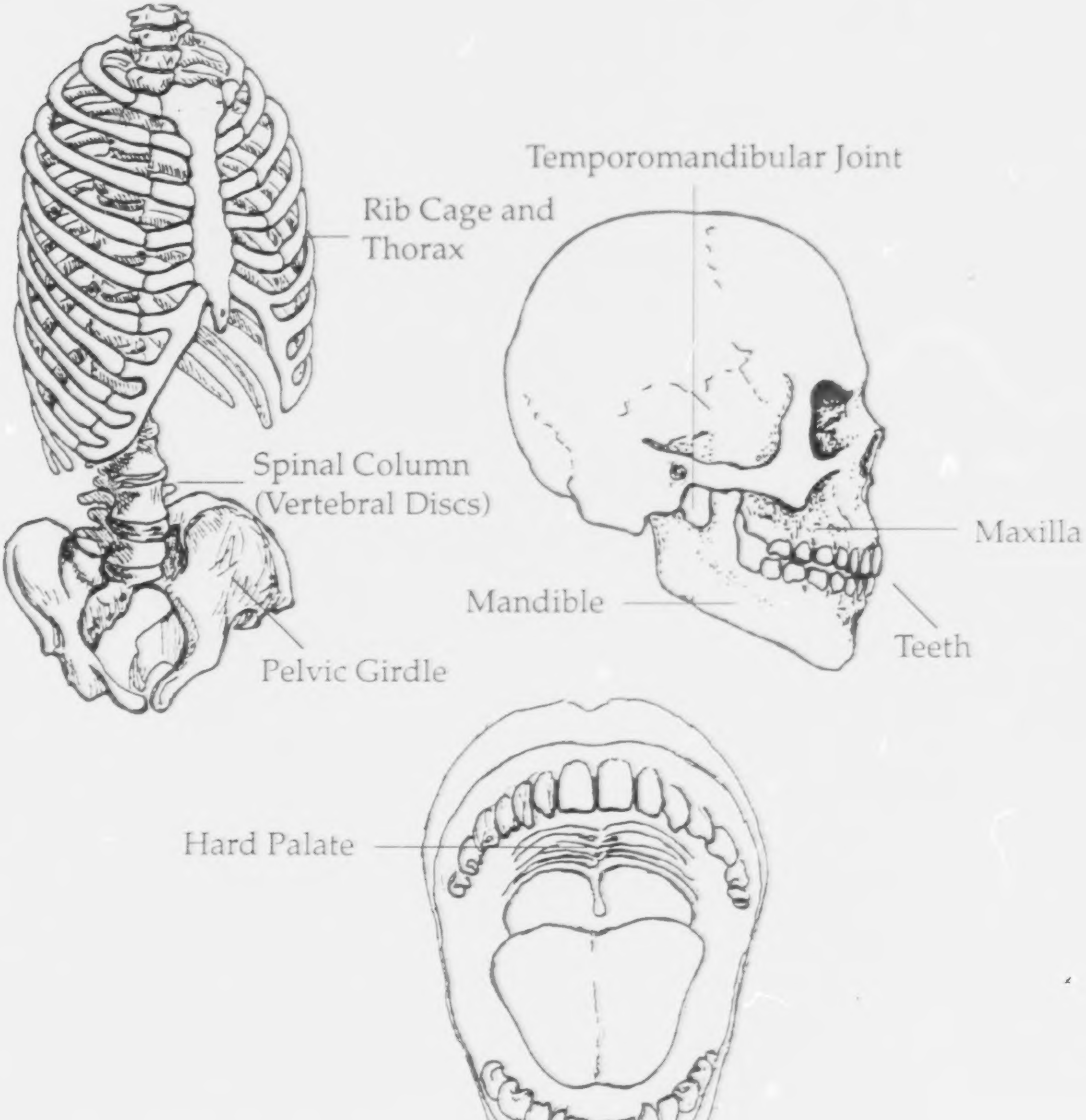

Incomplete
(greenstick)
Complete

Compound (Open) Fracture



# Skeletal Structures

## Affecting Production of Speech


Temporomandibular Joint
Rib Cage and Thorax
Spinal Column (Vertebral Discs)
Pelvic Girdle
Maxilla
Mandible
Teeth
Hard Palate

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV: FUNCTIONAL ANATOMY AND PHYSIOLOGY

SCOPE OF UNIT:

This unit covers aspects of anatomy and physiology of the long-term care resident which impact directly on function and the restorative process. Body systems covered in this unit include the skeletal system, the muscular system, the nervous system, and the sensory system.

INFORMATION TOPIC: IV-2 OR DEMONSTRATION:

## MUSCULAR SYSTEM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Given a diagram of a muscle and joint, label the origin and insertion, and indicate the direction of the contraction.
3. Match the three types of muscle to characteristics of each.
4. Label drawings of skeletal muscle movements.
5. Match common muscular disorders to their effects.
6. Label articulatory and respiratory structures which could be affected by muscular deficits.
7. Name the three main processes in the production of speech.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Types and Characteristics of Muscles
2. HO 2: Movement of Skeletal Muscle and Joints
3. HO 3: Speech Structures
4. References containing detailed illustrations of muscles of the body (posterior and anterior views)
5. Skeleton, if available

INFORMATIONAL ASSIGNMENT: (Student)

*Nurse Assistant in a Long-Term Care Facility*. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

REFERENCES: (Instructor's Additional Information)

Benson, Harold J. and Stanley E. Gunstream. *Anatomy and Physiology Laboratory Textbook*. Dubuque, IA: William G. Brown Company Publishers, 1978.

Darley, F.L., et.al. *Motor Speech Disorders*. Philadelphia: W.B. Saunders Co., 1975.

*Dorland's Pocket Medical Dictionary*. 24th ed. Philadelphia: W.B. Saunders Co., 1989.

Ferguson, Diana. *Physical Therapy Aide Student Manual*. Austin: Center for Occupational Curriculum, University of Texas at Austin, 1982.

*Nurse Assistant in a Long-Term Care Facility*. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

Netsell, Ron. *Speech Physiology*. In F. Minifie, T. Hixon, and F. Williams (eds.) *Normal Aspects of Speech, Hearing, and Language*. Englewood Cliffs, Prentice-Hall, 1988.
Nicholosi, L., et. al. *Terminology of Communication Disorders*. Baltimore: Williams and Wilkins, 1983.

Zemlin, W.R. *Speech and Hearing Science: Anatomy and Physiology*. Englewood Cliffs: Prentice-Hall, 1988.

INTRODUCTION:

Muscles aid in our appearance and mobility. If you don't use them, you lose them. If you can't use them, you need rehabilitative/restorative care. As an RNA, you will be responsible for range of motion exercises on residents. In this lesson we will also discuss some common muscular disorders you will probably be working with as you provide restorative care to the residents.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

OUTLINE: (Key Points)

I. Terms and Definitions

- A. Tendon - a band or cord of white fibrous tissue which provides a firm attachment of the muscle to the bone
- B. Muscle - a type of tissue composed of cells or fibers which affects movement of an organ or part of the body
- C. Myoneural junction - the site on a muscle cell or fiber where the nerve impulse from the brain tells the muscle to contract (shorten)
- D. Respiration - source of energy for speech
- E. Phonation - production of sound
- F. Vocal cords - ligaments located at the top of the larynx where phonation is produced
- G. Resonance - the quality, intensity, and duration of a speech sound

II. Three Types of Muscles and Their Characteristics (HO 1) (II-1)

- A. Involuntary muscle
  1. Controlled by the autonomic nervous system (automatically)
  2. Movement is unconscious
  3. Examples include: movement of food through the digestive tract and movement of blood through the blood vessels
- B. Cardiac muscle
  1. Controlled automatically
  2. Special striped muscle found only in the heart
- C. Voluntary (skeletal) muscle (II-2)
  1. Controlled by the central nervous system
  2. Movement is conscious or under the command of the person

3. These muscles are attached to bones and control the movement of the joints of the body

   a. Origin - the more fixed end or attachment of a muscle

   b. Insertion - the place of attachment of the muscle to the bone which it moves

   c. Contraction - activity which creates tension in a muscle with or without movement

   d. Myoneural junction - the site on each muscle fiber where the nerve impulse tells the muscle to contract (usually located at mid-fiber)

III. Movements of Skeletal Muscle and Joints Which May Be Impaired (HO 2) (II-3)

A. Flexion - to bend; shorten the angle between two adjoining bones of a joint (examples: head to chest at the neck and forearm to humerus at the elbow)

B. Extension - to straighten; increase the angle between two adjoining bones of a joint; opposite of flexion (example: straightening the arm)

C. Adduction - toward the center of the body; to move a body part toward the body (example: raised arm out to side of the body and down)

D. Abduction - away from the center of the body; opposite of adduction

E. Supination - to turn upward (example: turn palm of hand up)

F. Pronation - to turn downward; opposite of supination (example: turn palm of hand down)

G. Rotation - rolling or turning a bone in or out (only in ball and socket joints like the hip and shoulder)

H. Circumduction - a rotational movement of a limb in which the end of the limb would draw a circle (only in ball and socket joints)

IV. Common Muscular Deficits or Disorders Affecting Mobility (II-4)

A. Paralysis - temporary or permanent loss of muscle function to a part of the body; caused by injury, trauma, or illness

B. Contracture - temporary or permanent shortening (abnormal) of a muscle which results in a "frozen" or fixed joint; caused by paralysis or disuse

C. Atrophy - decrease in muscle size; usually in LTC, caused by disuse of a muscle or limb associated with illness or injury

D. Dystrophy - a genetic muscle disease which causes progressive atrophy and muscle wasting

V. Physiology of Speech (II-5)

A. Respiration - source of energy for speech

1. Muscles used to pump air through larynx

2. Muscles used to coordinate breathing and speaking

B. Phonation - production of sound

1. Air moving up from the lungs is transformed to sound at the larynx.

2. Muscles of larynx used to open and close vocal cords in the larynx.

3. Muscles also used to adjust pitch.

C. Articulation - modification of the air stream necessary to produce speech

1. Muscles of the articulators move articulators to modify the air stream.

2. Articulators can interrupt the flow of air to produce speech.

VI. Muscular Deficits Affecting Speech (HO 3)

A. Damage to muscles of the articulators could affect the following: (II-6)

1. Tongue - primary articulator necessary for the production of many speech sounds

2. Velum - soft palate; closes off air stream to the nose to allow air to flow through the mouth for some speech sounds; also opens airway to the nose during production of the nasal sounds "m", "n", and "ng."

3. Jaw - opens and closes the mouth

4. Lips - produce certain speech sounds

        5. Larynx - contains vocal cords; this is where phonation is produced

        6. Pharynx - throat; influences voice quality

    B. Damage to muscles of respiration could affect the following: (II-7)

        1. Abdominal muscles - help control the airflow

        2. Diaphragm - helps control the airflow

        3. Ribcage muscles - help control the airflow

VII. Summary and Conclusion

    A. Terms and definitions

    B. Three types of muscles and their characteristics

    C. Movements of skeletal muscle and joints which may be impaired

    D. Common muscular deficits or disorders affecting mobility

    E. Physiology of speech

    F. Muscular deficits affecting speech

The interdependency of the body systems becomes more and more obvious as we proceed through the lessons of this unit. The bones and joints are levers to be moved about by muscles which receive direction from yet another system to be discussed in our next lesson, the nervous system.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

INTERACTION ITEMS:

1. What types of muscles are in the body? Give an example of each.
2. What is the difference between skeletal and cardiac muscle?
3. What do you think are some of the common muscular disorders or problems that a LTC resident might have?
4. What are the three processes involved in speech production?
5. What are the six major articulatory structures which could be impaired by muscle weakness?
6. What are the three major structures necessary for respiration?
7. What are the three processes involved in speech production?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide the class into pairs and take turns doing the following:
    a. Identify major joints of the body and determine what movements each joint can perform and what muscles might be involved. (Example: the hip; abduction, adduction, rotation, flexion, extension)
    b. Choose a part of the body and make a list of the major muscles in that part. (Example: leg, arm, back, neck, abdomen)
    c. Palpate a muscle while it is contracting.
    d. Have students try to speak while purposely not using one of the muscles used to control movement of tongue, jaw, or lips.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the letter in the blank.

____ 1. A type of tissue composed of cells or fibers which affects movement of an organ or part of the body

____ 2. A band or cord of white fibrous tissue which provides firm attachment of muscle to bone

____ 3. The site on a muscle cell or fiber where the nerve impulse from the brain tells the muscle to contract

____ 4. The quality, intensity, and duration of a speech sound

____ 5. Source of energy for speech

____ 6. Ligaments located at the top of the larynx where phonation is produced

____ 7. Production of sound

a. Myoneural junction

b. Tendon

c. Muscle

d. Vocal cords

e. Respiration

f. Resonance

g. Phonation

Match the three types of muscles to their characteristics by writing the correct letter in the blank.

____ 8. Controls movement of blood through the blood vessels

____ 9. Special striped muscle found only in the heart

____10. Movement is controlled by the central nervous system

a. Cardiac muscle

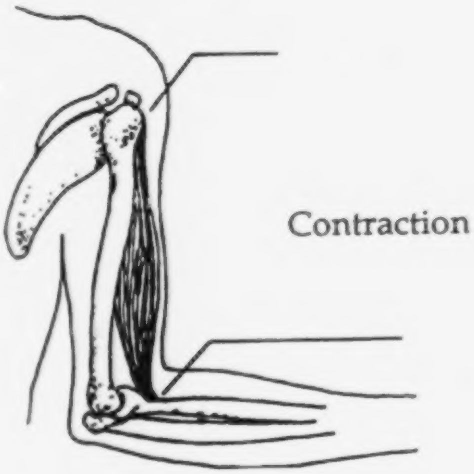
b. Skeletal muscle

c. Involuntary muscle

Match the following muscle disorders with their effects by writing the correct letter in the blank.

| | | | |
|---|---|---|---|
| ____11. | Genetic muscle disease causing progressive decrease in muscle size and wasting of muscle | a. | Atrophy |
| | | b. | Paralysis |
| ____12. | Temporary/permanent abnormal shortening of a muscle causes "frozen" joint | c. | Contractures |
| | | d. | Dystrophy |
| ____13. | Decrease in muscle size | | |
| ____14. | Temporary/permanent loss of muscle function to a part of the body; caused by injury, trauma, or illness | | |

15. On the diagram showing an elbow with a biceps attached shown below, label the origin and the insertion, and draw an arrow pointing in the direction of the contraction.



16. List the three processes involved in the production of speech.

a.

b.

c.

134

Match each illustration to the appropriate term (kind of movement) by writing the letter of the appropriate illustration in the blank. Note: There may be more than one illustration that applies to a term.

_____17. Flexion

_____18. Extension

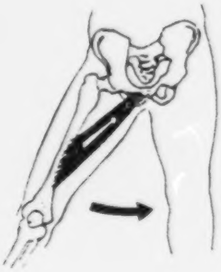
_____19. Abduction

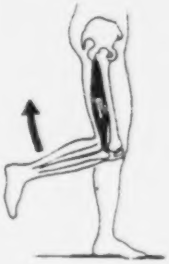
_____20. Adduction

_____21. Rotation

_____22. Supination

_____23. Pronation


a.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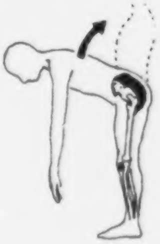
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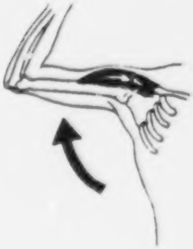
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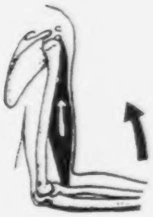
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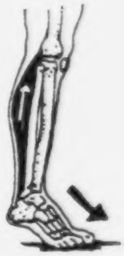
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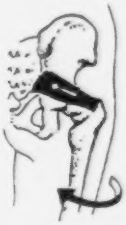
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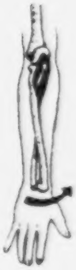
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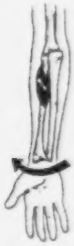
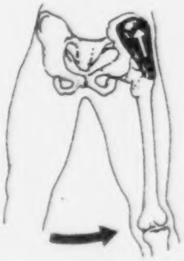

i.


j.

Identify the articulatory and respiratory structures shown in the illustration by writing the letter of the correct answer in the blank.

______24.

______25.

______26.

______27.

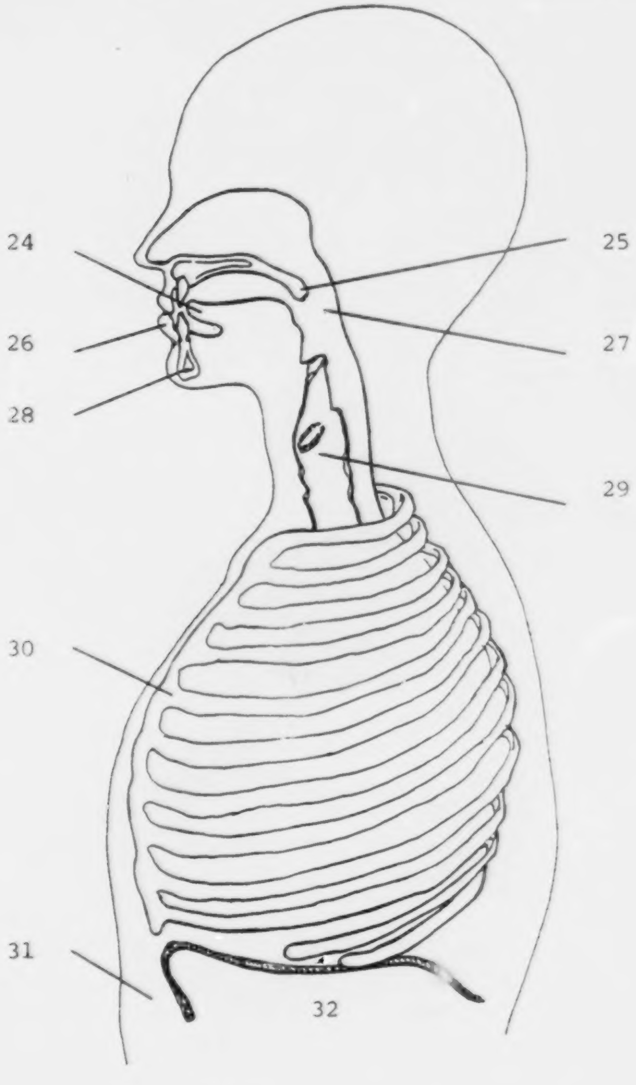
______28.

______29.

______30.

______31.

______32.



a. jaw

b. pharynx

c. diaphragm

d. velum

e. tongue

f. lips

g. ribcage

h. abdominal muscles

i. larynx

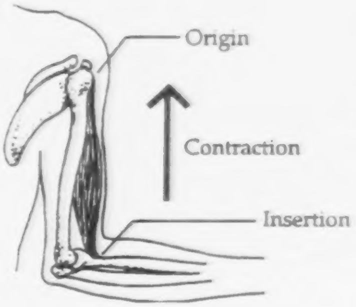
LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

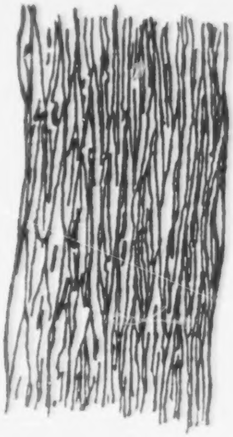
ANSWERS TO EVALUATION ITEMS:

1. c
2. b
3. a
4. f
5. e
6. d
7. g
8. c
9. a
10. b
11. d
12. c
13. a
14. b
15.

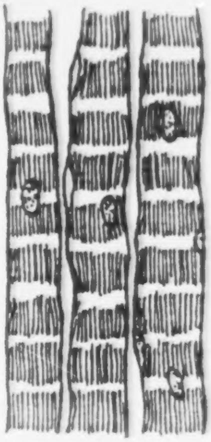


16. a.Respiration
    b.Phonation
    c.Articulation
17. b,e
18. c,f
19. d,j
20. a
21. g
22. i
23. h
24. e
25. d
26. f
27. i
28. a
29. b
30. g
31. h
32. c

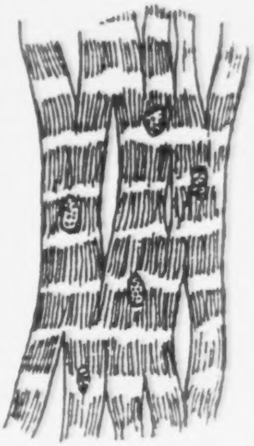
# Types and Characteristics of Muscles



Involuntary Muscle



Voluntary (skeletal) Muscle



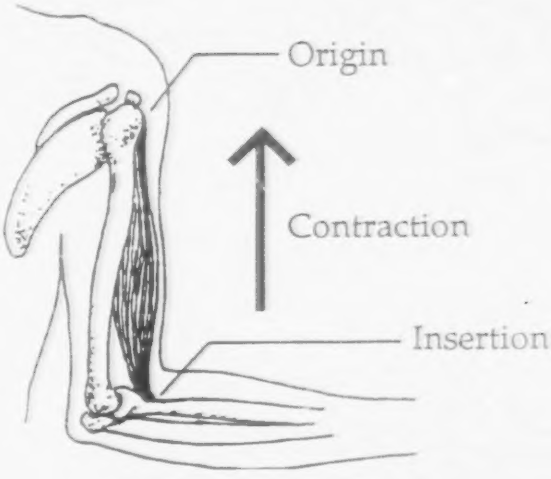
Cardiac Muscle

- Controlled by autonomic nervous system
- Movement is unconscious
- Controlled by central nervous system

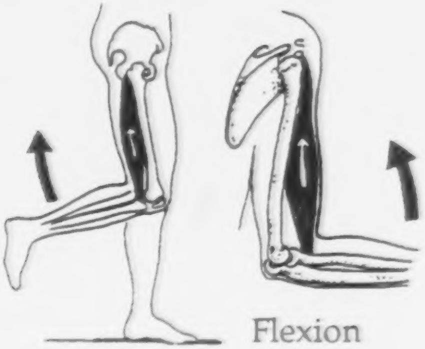
- Movement is conscious
- Attached to bones; controls movement of joints

- Controlled automatically
- Special striped muscle found only in the heart

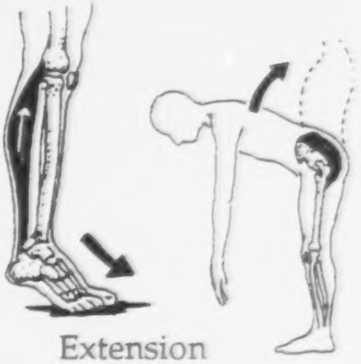
All Skeletal Muscles Have:



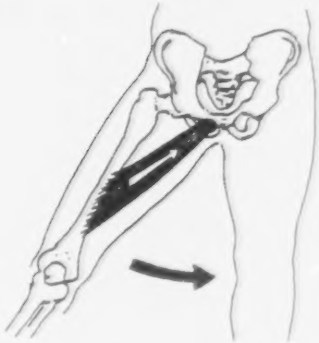
# Movement of
## Skeletal Muscles and Joints



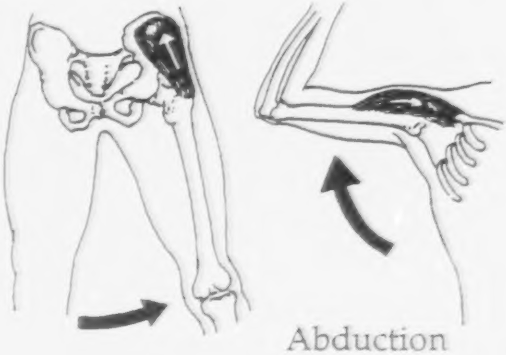
Flexion



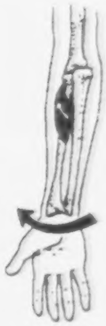
Extension



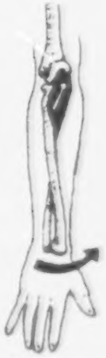
Adduction



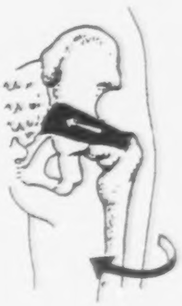
Abduction



Supination



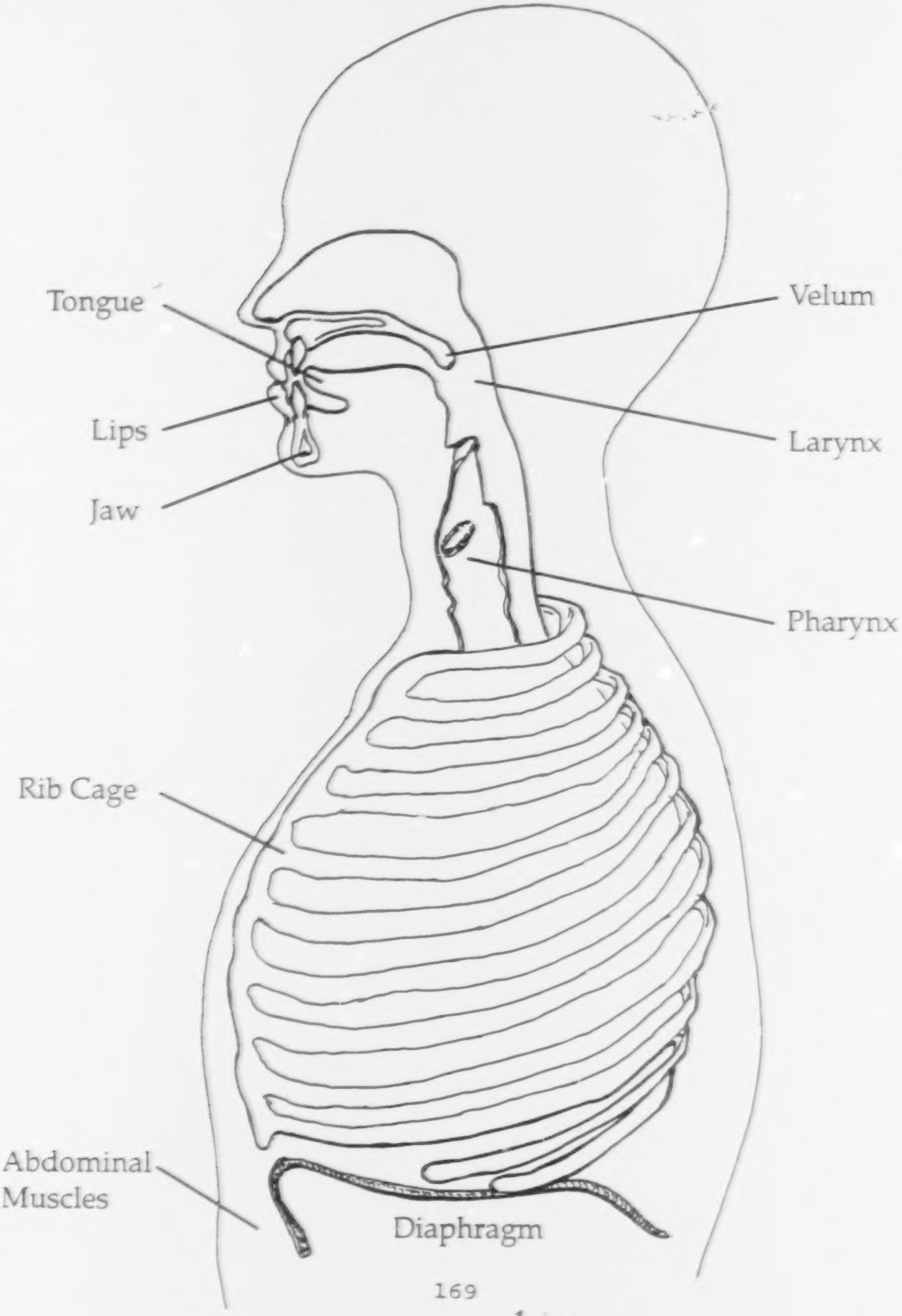
Pronation



Rotation

Circumduction

# Speech Structures


Tongue
Lips
Jaw
Velum
Larynx
Pharynx
Rib Cage
Abdominal Muscles
Diaphragm

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

SCOPE OF UNIT:

This unit covers aspects of anatomy and physiology of the long-term care resident which impact directly on function and the restorative process. Body systems covered in this unit include the skeletal system, the muscular system, the nervous system, and the sensory system.

INFORMATION TOPIC: IV-3 OR DEMONSTRATION:

NERVOUS SYSTEM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify functions of the nervous system.
3. List the three major parts of the nervous system.
4. Match parts of the nervous system to definitions, characteristics, and/or functions of each.
5. Match some common diseases of the nervous system to their causes and effects.
6. Identify language deficits associated with cranial nerve damage.
7. Identify language deficits associated with damage to the language centers in the left brain.
8. Identify language deficits associated with damage to the right brain.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Nervous System
2. HO 2: Language Centers of the Left Brain
3. Several references containing detailed illustrations of the nervous system

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Benson, Harold J. and Stanley E. Gunstream. Anatomy and Physiology Laboratory Textbook. Dubuque, IA: William G. Brown Company Publishers, 1978.

Brookshire, Robert H. An Introduction to Aphasia. Minneapolis: BRK Publishers, 1986.

Burn, M., et al. Clinical Management of Right Hemisphere Dysfunction. Rockville: Aspen Systems Corporation, 1985.

Darley. F.L. Aphasia. Philadelphia: W.B. Saunders Co., 1982.

Darley, F.L., et al. Motor Speech Disorders. Philadelphia: W.B. Saunders Co., 1975.

Ferguson, Diana. Physical Therapy Aide Student Manual. Austin: Center for Occupational Curriculum, University of Texas at Austin, 1982.

INTRODUCTION:

It is through our nervous system that our body receives direction and responds to it. Does it not then make sense that if any part of it is damaged or impaired, full coordination and cooperation of all body parts may not happen? Some actions are thought through and deliberate (voluntary), whereas others happen without our even realizing it (involuntary/autonomic). In this lesson, you will use your brain to think, learn, and respond to information you are about to receive.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Autonomic - functionally independent without control

  B. Broca's area - language center usually in the left hemisphere of the brain which controls planning and executing speech

  C. Cerebral - having to do with the largest part of the brain

  D. Dysarthria - speech impairment due to muscle weakness as a result of brain damage

  E. Peripheral - away from the center or middle

  F. Prosody - stress and intonation patterns of speech

  G. Wernicke's area - language center usually in the left hemisphere of the brain which controls understanding speech and selecting items to communicate

II. Functions of the Nervous System (II-1)

  A. The communication network of the body - one part with another

  B. Allows messages to be sent throughout the body

  C. Allows the brain to control many of the body's actions (example: contraction of a muscle)

  D. Allows us to know and respond to our environment (example: stepping on a nail sends a signal of pain to the brain and the brain tells the foot to pull away)

  E. Enables a network of nerve tissues to connect the other systems including muscular, sensory, circulatory, and endocrine (glands) so they can work together

III. Parts of the Nervous System (TM 1) (II-2)

  A. Central nervous system

    1. Brain

a. Cerebrum - the largest part of the brain

    1) Involved with actions, memory, thought, and voluntary decisions

    2) Receives and interprets nerve impulses from sensory system like eyes, ears, nose, tongue, and skin

b. Cerebellum - located below the cerebrum; controls body balance, equilibrium, and muscular coordination

c. Medulla oblongata - located at the lower portion of the brain and at the top (enlarged) of the spinal cord; controls respirations, temperature, and heartbeat

2. Spinal cord - oval column of nervous tissue that descends through the vertebra from the medulla to the second lumbar vertebra

    a. Supplies all the nerves of the limbs and trunk; comes from spinal cord

    b. Controls reflex action (example: knee jerk); message doesn't go all the way to the brain

    c. Contains the pathways that carry messages to and from the brain

B. Peripheral nervous system

1. Cranial nerves - twelve pairs of nerves that originate in the brain (one supplies the left side, the other the right)

    a. Primarily involved with the muscular and sensory control of the sense organs

    b. Lower two cranial nerves are also related to some control of the head and upper trunk

2. Spinal nerves - 31 pairs of nerves that originate in the spinal column; exit through the spaces between the vertebra

    a. Supplies a pathway for messages to and from the spinal cord

    b. Base for all nerves of the limbs and most of the trunk

    c. In the event of an injury to the column, spinal nerves below the affected vertebra are also usually affected

C. Autonomic nervous system

   1. Made up of nerve centers (ganglia) on either side of spinal cord and the nerves that carry messages directly to and from the brain and the spinal cord

   2. Involuntarily controlled and cannot be governed by thinking

   3. Control the involuntary muscles of the body which are responsible for the movement of food through the digestive tract and the circulation of blood to and from the heart

IV. Common Diseases or Disorders of the Nervous System (II-3)

A. Brain disorders

   1. Cerebral vascular accident (CVA) - commonly referred to as a "stroke"

      a. Usually caused by a hemorrhage or blockage of an artery in the brain

      b. Usually secondary to sclerosis (narrowing) of the artery, hypertension, or both

      c. Depending on the location of the hemorrhage, can cause the resident to display one or several characteristics including (but not limited to) paralysis, speech problems, and loss of sensation

   2. Cerebral palsy

      a. A permanent paralysis affecting both sides of the body which is caused by developmental defects in the brain or injury to the brain at birth, or infections like encephalitis

      b. Depending on the location of the injury or illness, can result in spastic paralysis, brain damage, exaggerated reflexes, and speech, sight, or hearing disorders

   3. Parkinson's disease

      a. Caused by lack of a chemical in the brain cells necessary for muscle control

      b. Often responds well to drug therapy using drugs which help to replace the missing chemical, however the effects of the drugs diminish over years of treatment

c. Characteristics include (but are not limited to) shuffling (slow, short steps), hand tremors, and slurred speech.

B. Spinal cord injuries/diseases

1. Multiple sclerosis

a. A degenerative disease which causes the forming of scar-like lesions in the brain, spinal cord, or peripheral nerves, which slow down or stop the transmission of nerve messages

b. Resident often experiences periods where symptoms decrease (remission) and then worsen (exacerbation).

c. Characteristics include speech and vision problems, weakness or paralysis of muscles of the limbs, loss of sensation, and mental problems ranging from depression to euphoria.

2. Quadriplegia - cervical vertebra one to thoracic vertebra two

a. Caused by illness or injury which affects the function of the arms and legs (depends on the location of the injury/lesion as to which parts are paralyzed)

b. Often results in incontinence, loss of control of limbs and trunk muscles, sometimes affects breathing muscles

3. Paraplegia - below thoracic vertebra two

a. Caused by illness or injury affecting two extremities, usually the legs (arms normal)

b. Depending on the level of the injury to the spinal cord or illness, the resident may experience incontinence, paralysis of the legs resulting in confinement to wheelchair or ambulation with crutches.

c. In some cases where spinal cord has been bruised, some or all muscle function can return; however, if spinal cord is severed, the resident will not return to normal.

V. Neurological Factors Affecting Speech and Language

A. Damage to cranial nerves - can result in dysarthria; nerves that make muscles work are damaged making muscles weak or paralyzed

   1. Impairment of articulation - residents have difficulty moving lips, tongue, jaw, and soft palate due to muscle weakness

   2. Impairment of respiration - residents have difficulty moving diaphragm, rib cage, and pelvis for breathing and speaking

   3. Impairment of stress and intonation (prosody)- decreased ability to adjust pitch and intensity of voice due to damage to certain cranial nerves

   4. Impairment of voice - voice may be breathy, harsh, or strangled due to weak operation of vocal cords

B. Damage to language centers of the left brain (TM 2)

   1. Broca's area

      a. Affects planning movements needed to produce spoken message

      b. Affects production of spoken message

   2. Wernicke's area

      a. Affects comprehension of speech

      b. Affects selection of items to communicate

C. Damage to the right brain or nondominant hemisphere can cause:

   1. Cognitive deficits such as poor memory, poor ability to problem-solve, errors in judgment, etc.

   2. Attention problems such as failing to stay with a task or not listening to instructions

   3. Problems with language usage or fundamentals such as staying on topic or taking turns speaking

   4. Problems interpreting and using abstract language such as interpreting common expressions and phrases or understanding humor

   5. Visual problems such as neglecting to see things on the left side or difficulty recognizing familiar faces

   6. Dysarthria

## VI. Summary and Conclusion

A. Terms and definitions

B. Functions of the nervous system

C. Parts of the nervous system

D. Common diseases or disorders of the nervous system

E. Neurological factors affecting speech and language

If your right brain or nondominant hemisphere has been working for you, cognitive learning has taken place and you can now, through your own nervous system, coordinate your new knowledge into skills. In the next unit we will discuss some chronic health problems found in LTC which may impair the resident's ability to think and move.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

INTERACTION ITEMS:

1. What are the parts of the nervous system?
2. What are the functions of the nervous system?
3. What are some common diseases or disorders of the nervous system?
4. What are some speech problems associated with cranial nerve damage?
5. How is language affected if the left brain language centers are damaged?
6. What are some possible behavioral manifestations of right brain damage?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide the class into pairs and take turns doing the following:
    a. Palpate and identify the vertebrae of the body.
    b. Identify which body functions and systems might be affected when given the level of injury/illness by the instructor.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the letter in the blank.

____ 1. Functionally independent without control

____ 2. Having to do with the largest part of the brain

____ 3. Away from the center or middle

____ 4. Language center usually in the left hemisphere of the brain which controls planning and executing speech

____ 5. Stress and intonation patterns of speech

____ 6. Speech impairment due to muscle weakness as a result of brain damage

____ 7. Language center usually in the left hemisphere of the brain which controls understanding speech and selecting items to communicate

a. Peripheral

b. Autonomic

c. Cerebral

d. Wernicke's area

e. Prosody

f. Dysarthria

g. Broca's area

8. It is the function of the nervous system to: (Circle the letter of the correct answer)

   a. Allow us to know and respond to our environment
   b. Allow us to send messages throughout the body
   c. Allow the brain to control many of the body's actions
   d. All of the above

9. The three major parts of the nervous system are:

   a.

   b.

   c.

Match the following parts of the nervous system to functions, definitions, and/or characteristic of each by writing the correct letter in the blank.

_____ 10. Are involuntarily controlled and cannot be controlled by thinking

_____ 11. 12 pairs of nerves that originate in the brain

_____ 12. Made up of the cerebrum, cerebellum, and the medulla oblongata

_____ 13. Controls reflex action (knee jerk) - the message doesn't go all the way to the brain

_____ 14. 31 pairs of nerves that are the base for all nerves of the limbs and most of the trunk

a. Spinal cord

b. Brain

c. Autonomic nerves

d. Spinal nerves

e. Cranial nerves

Match the following diseases or disorders to their causes or effects by writing the correct letter in the blank.

_____15. Caused by injury/illness affecting function of arms and legs

_____16. Caused by lack of a chemical in the brain cells necessary for muscle control

_____17. A degenerative disease characterized by the formation of scar-like lesions and periods of remission and exacerbation

_____18. A permanent paralysis affecting both sides of the body and caused by developmental defects, injury at birth, or infections like encephalitis

_____19. Caused by injury/illness to the spinal cord below thoracic vertebra two and usually affecting the legs

_____20. Usually caused by hemorrhage or blockage of artery in brain; associated with hypertension

a. Multiple sclerosis

b. Parkinson's disease

c. Paraplegia

d. Quadriplegia

e. CVA

f. Cerebral palsy

Match the language deficit to the cause associated with it by writing the correct letter in the blank. NOTE: Letters may be used more than once.

_____21. Impairment of respiration

_____22. Affects planning a spoken message

_____23. Produces cognitive deficits

_____24. Problems staying on topic

_____25. Affects comprehension of speech

_____26. Impairment of voice

_____27. Problems with abstract language

_____28. Affects producing a spoken message

_____29. Affects selecting items to communicate

a. Damage to cranial nerves

b. Damage to language centers of the left brain

c. Damage to right brain

LESSON PLAN: 3

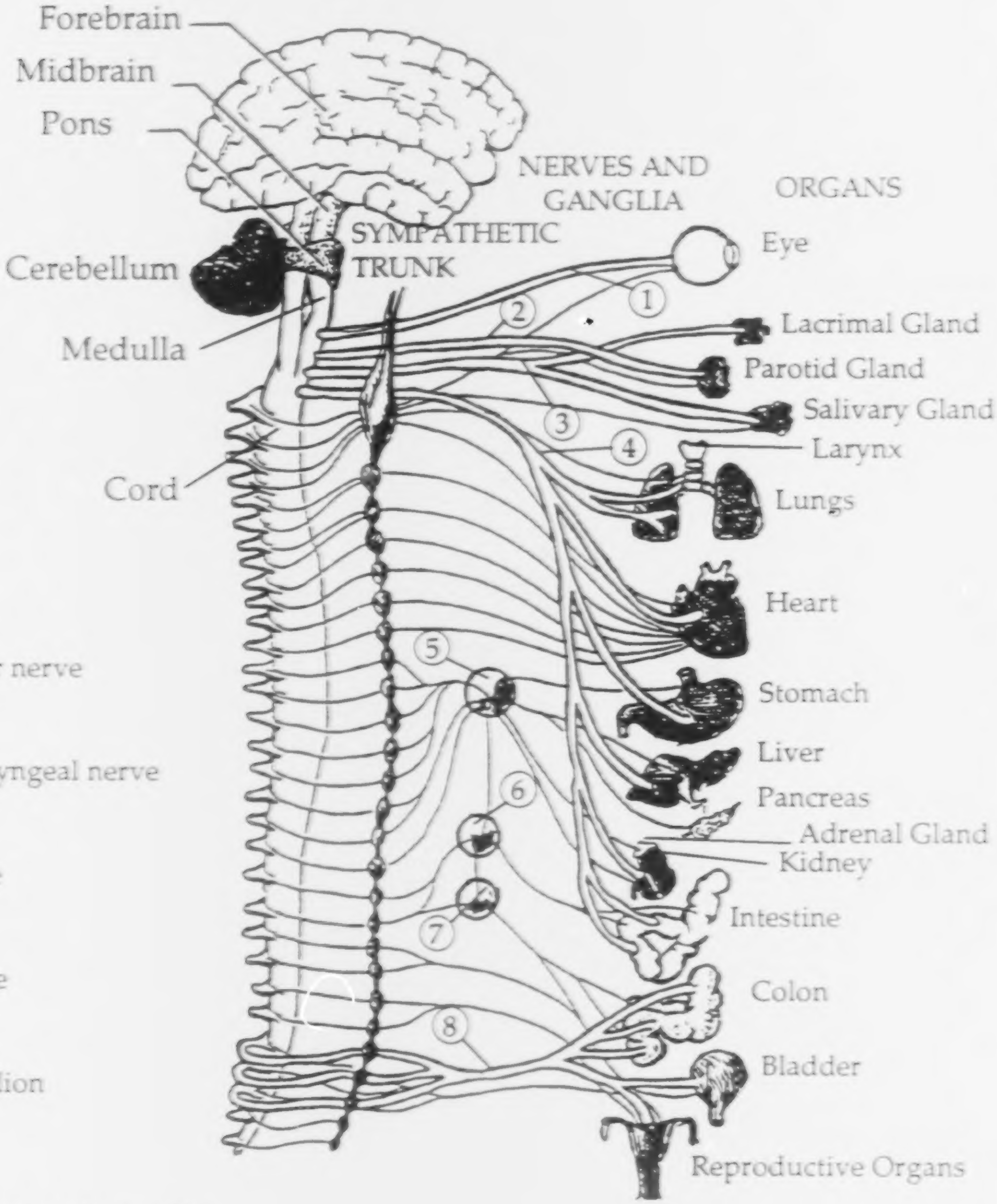
COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

ANSWERS TO EVALUATION ITEMS:

1. c
2. a
3. b
4. g
5. e
6. f
7. d
8. d
9. a. Central
   b. Peripheral
   c. Autonomic
10. d
11. c
12. a
13. e
14. b
15. c
16. b
17. e
18. a
19. f
20. d
21. a
22. b
23. c
24. c
25. b
26. a
27. c
28. b
29. b

# The Nervous System


Forebrain
Midbrain
Pons
Cerebellum
Medulla
Cord
SYMPATHETIC TRUNK
NERVES AND GANGLIA
ORGANS
Eye
Lacrimal Gland
Parotid Gland
Salivary Gland
Larynx
Lungs
Heart
Stomach
Liver
Pancreas
Adrenal Gland
Kidney
Intestine
Colon
Bladder
Reproductive Organs
①
②
③
④
⑤
⑥
⑦
⑧

①
Oculomotor nerve

②
Glossopharyngeal nerve

③
Facial nerve

④
Vagus nerve

⑤
Celiac ganglion
and plexus

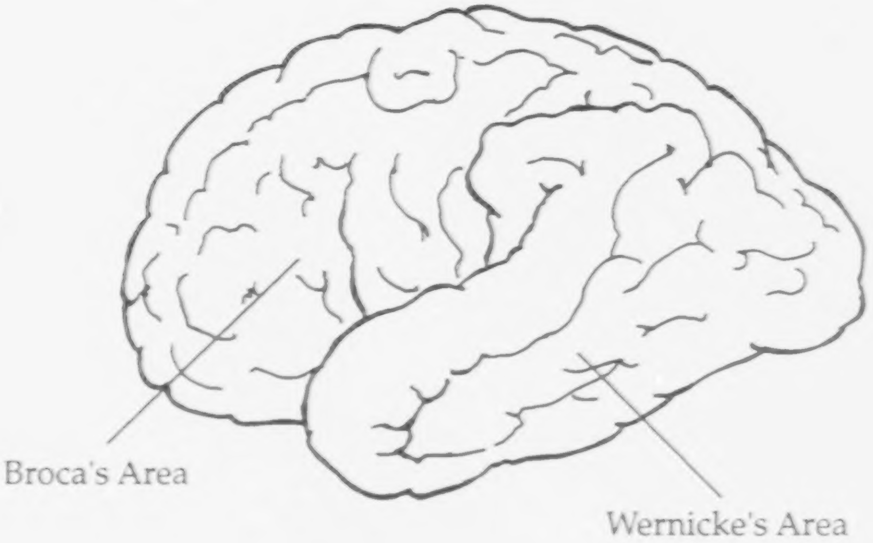
⑥
Superior mesenteric ganglion

⑦
Inferior mesenteric ganglion and plexus

⑧
Pelvic nerve

# Language Centers

## of the Left Brain


Broca's Area
Wernicke's Area

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

SCOPE OF UNIT:

This unit covers aspects of anatomy and physiology of the long-term care resident which impact directly on function and the restorative process. Body systems covered in this unit include the skeletal system, the muscular system, the nervous system, and the sensory system.

INFORMATION TOPIC: IV-4 OR DEMONSTRATION:

SENSORY SYSTEM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms related to sensory deficits with their corresponding characteristics.
2. Label parts of the eye on a diagram.
3. Label parts of the ear on a diagram.
4. Trace the steps sound waves travel from the time they enter the auricle until they are given meaning in the brain.
5. Identify characteristics of conductive and sensorineural hearing loss.
6. Identify common sensory losses associated with the gustatory, olfactory, and tactile senses.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Anatomy of the Eye
2. HO 2: Anatomy of the Ear
3. Several references containing detailed illustrations of the sensory system

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Bollinger, R.L., et al. Communication Management of the Geriatric Patient. Danville: The Interstate Printers and Publishers, Inc., 1977.

Davis, H. "Abnormal Hearing and Deafness." In H. Davis and S.R. Silverman (eds.) Hearing and Deafness. New York: Holt, Rinehart and Winston, 1970.

Davis, H. "Acoustics and Psychoacoustics." In H. Davis and S.R. Silverman (eds.) Hearing and Deafness. New York: Holt, Rinehart and Winston, 1970.

Davis, H. "Anatomy and Physiology of the Auditory System." In H. Davis and S.R. Silverman (eds.) Hearing and Deafness. New York: Holt, Rinehart and Winston, 1970.

Freeman, B.A. and J.S. Sinclair. "Hearing Aids for the Elderly." In D.S. Beasley and G.A. Davis (eds.) Aging: Communication Processes and Disorders. New York: Grune and Stratton, 1981.

Kasten, R.N. and McCroskey, R.L. "The Hearing Aid as Related to Rehabilitation. In J. Alpiner (ed.) Handbook of Adult Rehabilitative Audiology. Baltimore: Wililams and Wilkins, 1982.

Nicolosi, L., et al. Terminology of Communication Disorders. Baltimore: Williams and Wilkins, 1983.

Orchik, D.J. "Peripheral Auditory Problems and the Aging Process. In D.S. Beasley and G.A. Davis (eds.2) Aging: Communication Processes and Disorders. New York: Grune and Stratton, 1981.

Sanders, D.A. Aural Rehabilitation. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971.

Schow, R.L., et al. Communication Disorders of the Aged: A Guide for Health Professionals. Baltimore: University Park Press, 1978.

Zemlin, W.R. Speech and Hearing Science: Anatomy and Physiology. Englewood Cliffs: Prentice-Hall, Inc., 1988.

INTRODUCTION:

The sensory system is our link to our environment. Being able to see, hear, and touch makes our world more enjoyable. Having any of these senses compromised causes us to learn and function much differently.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

OUTLINE: (Key Points)

I. Terms and Definitions

A. Acuity - sharpness of a particular sense such as visual or auditory

B. Auditory - having to do with the sense of hearing

C. Auditory agnosia - difficulty recognizing anything heard even though hearing is sharp

D. Cataracts - clouding of the lens of the eye; corrected with lens implants following removal of the old lens

E. Cholesteatoma - a cyst, on or near the eardrum

F. Cochlea - organ of hearing

G. Ear drum - structures in the ear that work together to transmit sound to the inner ear

H. Eustacean tube - structure connecting the middle ear to the throat; responsible for regulating ear pressure

I. Glaucoma - increased intraocular pressure of the eye leading to blindness if unchecked

J. Gustatory - having to do with the sense of taste

K. Macular degeneration - spot on retina loses blood supply; receptors are damaged and central vision is lost

L. Olfactory - having to do with the sense of smell

M. Otitis media - middle ear infection

N. Otosclerosis - disease of bones of the middle ear

O. Presbycusis - age-related hearing impairment

P. Semicircular canals - sense organs for maintaining sense of balance

Q. Tactile - having to do with the sense of touch

R. Tinnitus - ringing in the ears

S. Visual - having to do with the sense of sight

T. Visual agnosia - difficulty recognizing anything seen even though vision is sharp

U. Visual field - range or area that can be seen by an individual

II. Basic Anatomy/Physiology of the Eye (HO 1)

A. External anatomy

1. Extrinsic (outer) muscles - control the eye movements

a. Movements right and left; and up and down

b. Blinking of eyelids

c. Bringing eyes together for objects up close (convergence)

d. Moving eyes apart for focusing on objects far away (divergence)

e. Assisting in accommodation to distance; near to far depth perception

2. Protection mechanisms (II-1)

a. Eyelids and eyebrows - protect eyes from dust and other airborne particles

b. Conjunctiva - thin membrane covering the exposed surface of the eye

(1) When irritated, blood vessels dilate

(2) Common infection is conjunctivitis or "pink eye"

c. Tears - contain bacteria-destroying enzyme

(1) Lacrimal gland - secretes tears and protects conjunctive by keeping it moist

(2) Lacrimal ducts - tears exit the eye through these and flow on through the nose

B. Internal anatomy

1. Retina - contains the rods and cones which differentiate image, light, and color

2. Optic nerve - contains nerve fibers leading from the rods and cones on the retina to the brain

where the image, light, and color are recognized; nerve entrance to the eye is called the blind spot or optic disk

3. Lens - an elliptical clear structure
    a. Focuses light entering the eye on the retina
    b. Suspended in the eye by a ligament which is attached to the ciliary body (changes the shape of the lens for focusing at different distances)
4. Iris - contains the eye pigment (brown, blue, green, etc.) and also contains regulating muscle fibers which change the size of the pupil and therefore control the amount of light entering the eye
5. Pupil - opening for light; dilated in low light and constricted in bright light
6. Cornea - the window to the eye; allows light to enter
7. Vitreous humor - the jelly-like substance through which light travels from the pupil to the retina

III. Visual Deficits which Interfere with Rehabilitation

A. Most common problems (II-2)

1. Glaucoma - increased intraocular pressure of the eye leading to hardening of the eyeball
2. Cataracts - clouding of the lens of the eye; corrected with lens implants following removal of the old lens
3. Macular degeneration - spot on retina loses blood supply; receptors are damaged and central vision is lost

B. Visual agnosia - the resident has normal visual acuity but has trouble recognizing anything visual. Usually the resident can identify objects or people by touch or hearing. Some types of visual agnosia include:

1. Difficulty recognizing objects
2. Inability to understand the meaning of a picture
3. Inability to identify colors

4. Inability to find way around because hallways, streets, houses all look alike

5. Difficulty recognizing faces

C. Blindness - resident cannot see

D. Visual field impairments - resident sees only portions of the visual field

E. Reduced visual acuity - resident experiences blurred vision, double vision, etc.

F. Resident is more sensitive to light

IV. Basic Anatomy/Physiology of the Ear (HO 2) (II-3)

A. Outer ear

1. Pinna or auricle - outer opening

a. Collects sound for transmission to the middle and inner ear

b. Judges direction of sound

c. Keeps water and dirt out of ear canal

2. Ear canal - external auditory meatus

a. Connects outer ear with ear drum

b. Produces ear wax (cerumen) which protects ear and keeps it moist

B. Middle ear

1. Tympanic membrane (eardrum) - structures in the ear which work together to transmit sound to inner ear; also protects inner ear from loud noises

2. Ossicles - bones of middle ear

a. Malleus - mallet

b. Incus - anvil

c. Stapes - stirrup

3. Eustacean tube - equalizes air pressure inside and outside the eardrum

4. Oval window - leads to inner ear

C. Inner ear

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        1. Cochlea - organ of hearing; contains sensory hair cells for detecting sounds

        2. Semicircular canals - sense organ for maintaining sense of balance

    D. Bone conduction - sound may be transported through bones of the skull as well as through the outer ear

    E. Role of the brain - sound is sent to the brain where meaning is attached to the sound (II-4)

V. Hearing Deficits and Types of Hearing Loss (II-5)

    A. Hearing deficits

        1. Auditory agnosia - resident has normal hearing acuity, but has trouble identifying anything presented to the ear; some types include:

            a. Agnosia for environmental sounds such as bells, horns, etc.

            b. Pure word deafness - inability to attach meaning to spoken words and phrases

        2. Hearing impairment - resident has reduced auditory acuity

        3. Deafness - resident cannot hear

    B. Conductive hearing loss - a loss due to disease or impairment in the outer or middle ear

        1. Characteristics of conductive loss

            a. Resident can hear better in noisy environments.

            b. Residents can still hear through the skull since the inner ear is not damaged.

            c. Impairment can be treated medically and can, therefore, improve.

        2. Causes of conductive hearing loss

            a. Impacted wax (II-6)

            b. Otitis media - inflammation of the middle ear; infection

            c. Cholesteatoma - cyst on or near the eardrum

            d. Allergy

e. Otosclerosis - bone disease affecting the malleus, incus, and stapes

C. Sensorineural - hearing loss resulting from disease or damage to the inner ear or along the nerve pathway from the inner ear to the brain stem

1. Characteristics of sensorineural hearing loss

a. Residents have difficulty hearing in a noisy environment.

b. Often have more difficulty hearing sounds at higher pitches.

c. Tinnitus - ringing in the ears; sometimes accompanies sensorineural hearing loss.

2. Causes of sensorineural hearing loss

a. Presbycusis - age-related hearing deterioration

b. Drugs or poisons

c. Noise - constant exposure to noises at high intensities

d. Acoustic trauma - injury to ear by single brief exposure to an explosion or a blow to the head

e. Congenital conditions and diseases

D. Mixed - a hearing loss containing aspects and characteristics of both conductive and sensorineural hearing loss

VI. Other Common Sensory Losses and the Senses Affected (II-7)

A. Gustatory - taste

1. Number of taste buds decrease; ability to identify sweet, salty, sour, bitter declines; sweet and salt are lost first

2. Strong interrelationship between taste and smell

B. Olfactory - smell

1. Sensitivity declines

2. Receptors fatigue rapidly

C. Tactile - touch

        1. Inability to maintain constant body temperature
        2. Reduced sensitivity to touch
        3. Sensation may be absent or impaired
            a. Post CVA - one side of body
            b. Multiple sclerosis - numbness in hands, feet

VII. Summary and Conclusion

    A. Terms and definitions
    B. Basic anatomy/physiology of the eye
    C. Visual deficits which interfere with rehabilitation
    D. Anatomy/physiology of the ear
    E. Hearing deficits and types of hearing loss
    F. Other common sensory losses and the senses affected

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

INTERACTION ITEMS:

1. What are the protective parts of the eye?
2. What are some hearing deficits which might interfere with a resident's rehabilitation?
3. What are the three main parts of the ear?
4. What part of the body attaches meaning to sounds we hear?
5. What are some hearing deficits which might interfere with a resident's rehabilitation?
6. What are the three main parts of the ear?
7. What are some of the ways that smell, touch, and taste can be affected by disease/illness?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Have students work in pairs to do these activities:

1. One student is blindfolded as his/her partner uses cotton swabs dipped in flavorings such as salt, sugar, lemon juice, and alumn to touch the blindfolded student's tongue and thus stimulate the gustatory receptors.
2. Take several pairs of old eyeglasses and paint the lens in the following manner: a) Paint both lens of one pair with translucent paint; b) Paint another pair with white paint, leaving only a tiny hold in the center of each lens clear; c) On a third pair, paint the lens diagonally with white paint. This exercise allows students to experience some visual limitations similar to those discussed in this lesson.
3. Have students wear gloves to open a cracker package; then add a blindfold and have them try to recognize objects by touch while still wearing the gloves. This exercise demonstrates effects of loss of touch and dexterity.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

EVALUATION ITEMS:

Match the following terms and/or sensory deficits to the correct definitions by writing the letter in the blank.

____ 1. A cyst, on or near the eardrum

____ 2. Increased intraocular pressure of the eye leading to blindness if unchecked

____ 3. Middle ear infection

____ 4. Age-related hearing impairment

____ 5. Ringing in the ears

____ 6. Difficulty recognizing anything heard even though hearing is sharp

____ 7. Spot on retina loses blood supply; receptors are damaged and central vision is lost

____ 8. Difficulty recognizing anything seen even though vision is sharp

____ 9. Clouding of the lens of the eye; corrected with lens implants

____ 10. Disease of bones of the middle ear

____ 11. Resident sees only part of what is in front of him/her

____ 12. Resident cannot hear

____ 13. Resident has reduced auditory acuity

____ 14. Resident experiences blurred vision

a. Auditory agnosia

b. Macular degeneration

c. Visual agnosia

d. Glaucoma

e. Cholesteatoma

f. Cataracts

g. Disease of bones of the middle ear

h. Otitis media

i. Otosclerosis

j. Otitis media

k. Tinnitus

l. Presbycusis

m. Reduced visual acuity

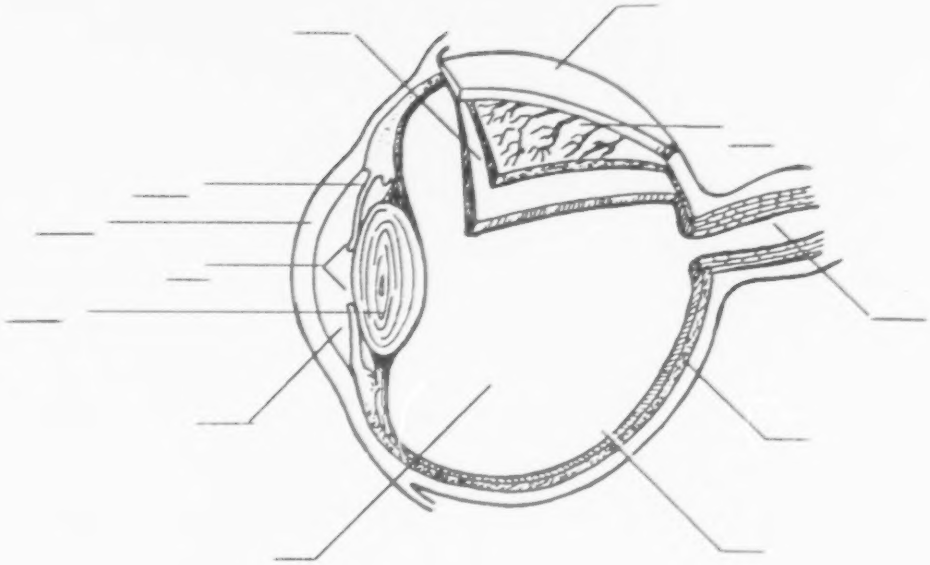
n. Hearing impairment

o. Visual field impairment

p. Deafness

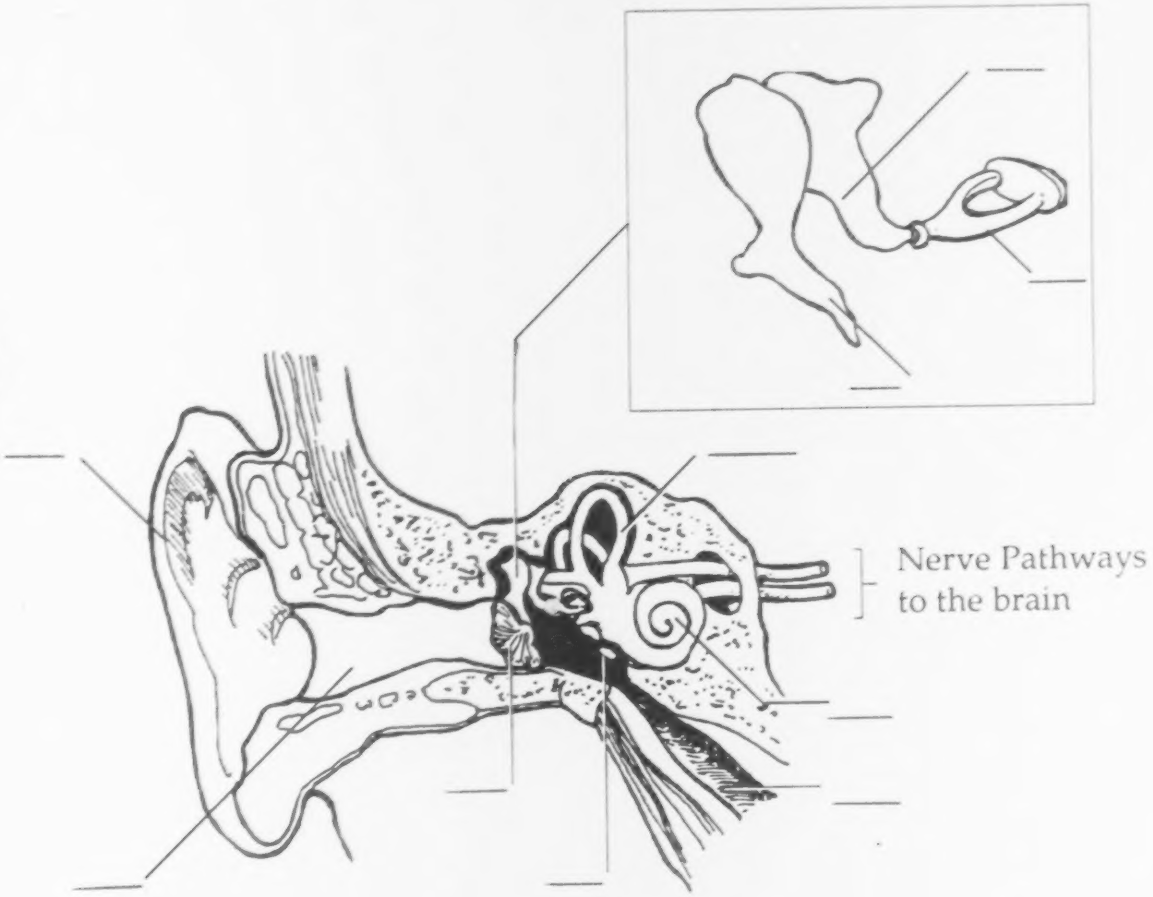
**Label the parts of the eye as indicated on the diagrams below by writing the number in the blank which corresponds to the correct part.**

15. Sclerotic coat
16. Choroid coat
17. Fovea
18. Lens
19. Cornea
20. Iris
21. Retina
22. Pupil
23. Optic nerve
24. Vitreous humor
25. Aqueous humor



Label the parts of the ear as indicated on the diagram below by writing the number in the blank which corresponds to the correct part.

26. Malleus
27. Incus
28. Cochlea
29. Eardrum membrane
30. External auditory meatus
31. Semicircular canals
32. Stapes
33. Eustachian tube
34. Oval window
35. Auricle



Put the following steps in the order in which they occur by writing the letter corresponding to the correct step in the blank.

|  |  |
|---|---|
| ____36. Sound is picked up by the auricle. | a. Step 1 |
| ____37. Meaning is attached to the sound. | b. Step 2 |
| ____38. The ossicles are in operation. | c. Step 3 |
| ____39. Sound is transmitted to the cochlea. | d. Step 4 |
| ____40. Sound waves travel through the ear canal. | e. Step 5 |

For each of the following characteristics of hearing loss, indicate by marking "a" if it is associated with conductive hearing loss, or "b" if it is associated with sensorineural hearing loss.

____41. Resident hears better in quiet.

____42. May be caused by impacted wax.

____43. Hearing through skull is better than hearing through ear.

____44. May be caused by allergy.

____45. May be congenital.

____46. May be treated medically.

Identify one sensory loss associated with each of the following senses.

47. Gustatory -

48. Olfactory -

49. Tactile -

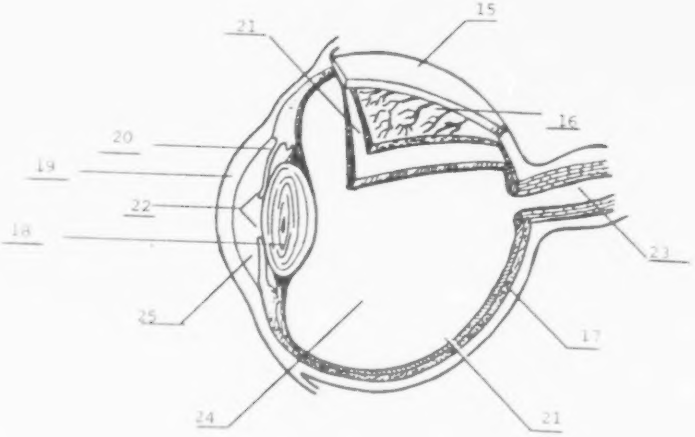
LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT IV : FUNCTIONAL ANATOMY AND PHYSIOLOGY

ANSWERS TO EVALUATION ITEMS:

1. e
2. d
3. h
4. j
5. k
6. a
7. b
8. c
9. f
10. i
11. o
12. p
13. n
14. m
15.-25. See diagram below


21
15
16
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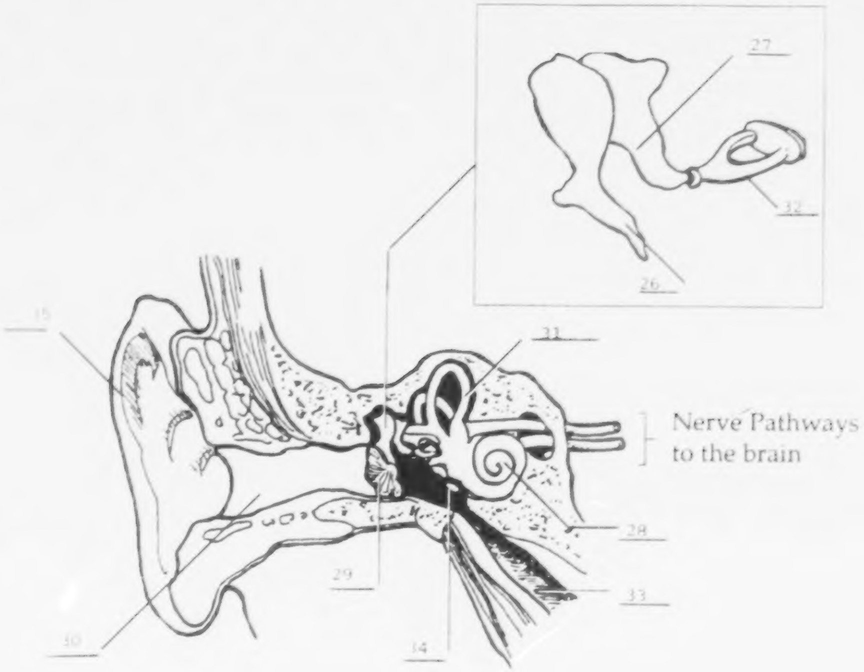
19
22
18
23
25
17
24
21

26.-35. See diagram below



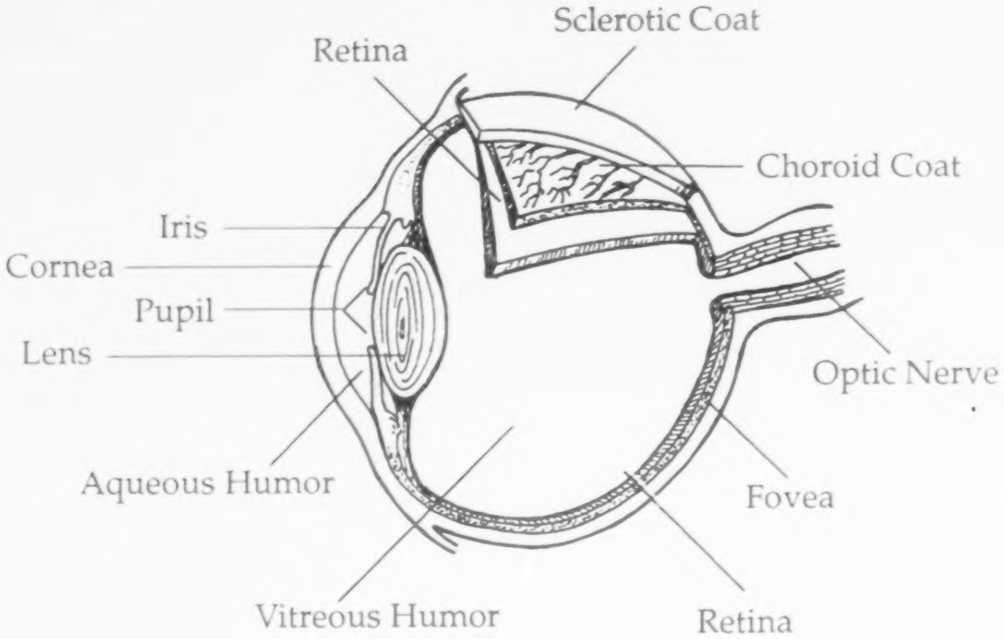
36. a
37. e
38. c
39. d
40. b
41. b
42. a
43. a
44. a
45. b
46. a
47. The student may list one of the following:
    a. Number of taste buds decrease; ability to identify sweet, salty, sour, bitter declines; sweet and salt are lost first
    b. Strong interrelationship between taste and smell

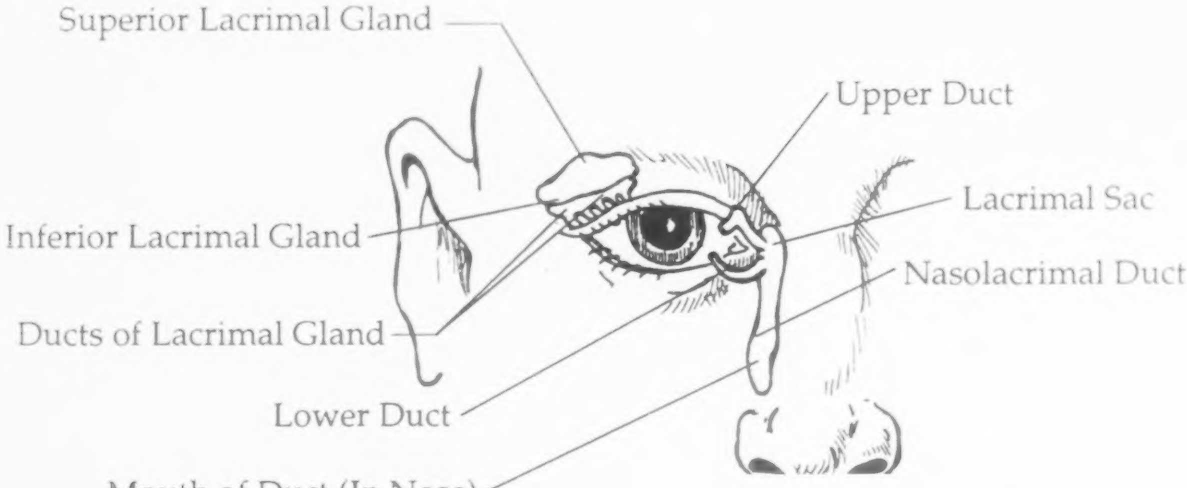
48. The student may list one of the following:
    a. Sensitivity declines
    b. Receptors fatigue rapidly

49. The student may list one of the following:
    a. Inability to maintain constant body temperature
    b. Reduced sensitivity to touch
    c. Sensation may be absent or impaired
        1) Post CVA - one side of body
        2) Multiple sclerosis - numbness in hands, feet

HO 1

# Anatomy of the Eye

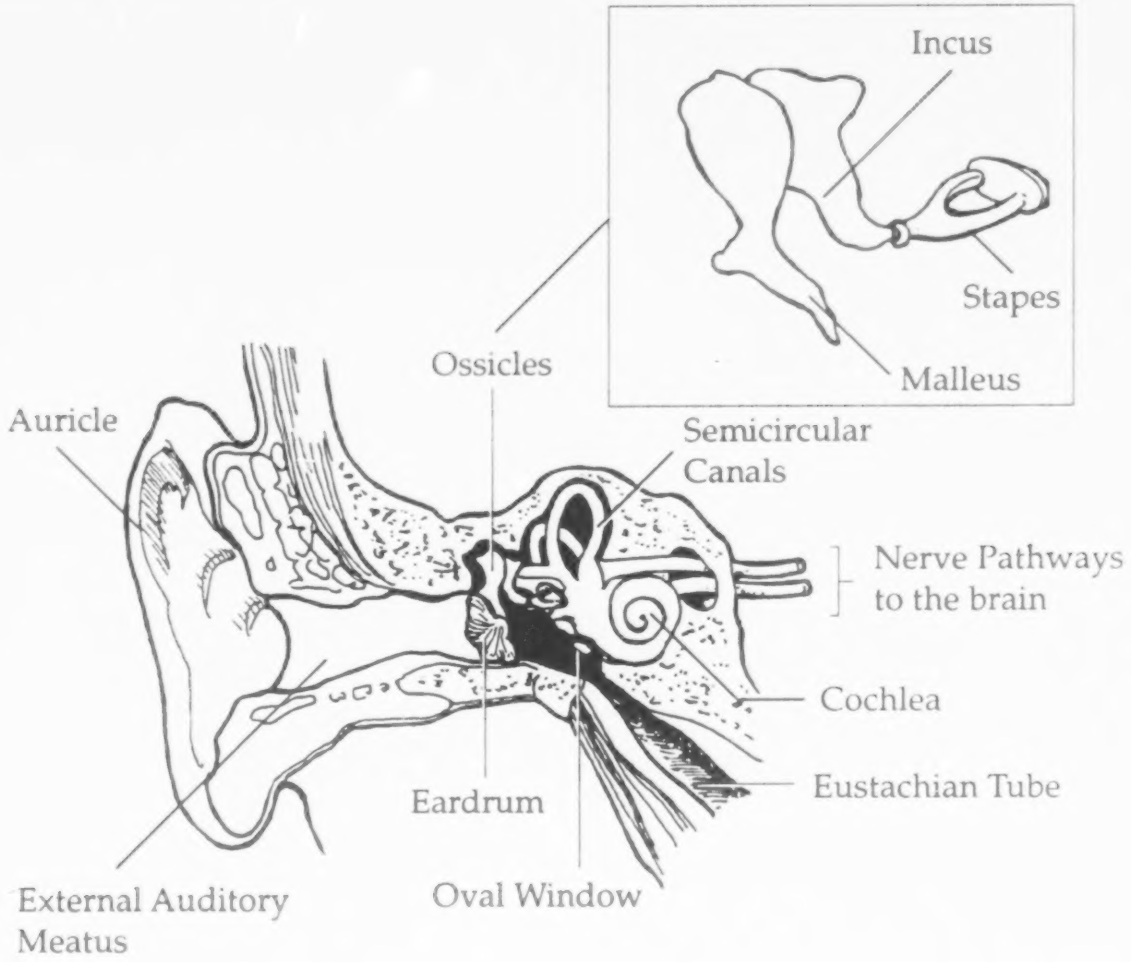

Sclerotic Coat
Retina
Choroid Coat
Iris
Cornea
Pupil
Lens
Optic Nerve
Aqueous Humor
Fovea
Vitreous Humor
Retina


Superior Lacrimal Gland
Upper Duct
Lacrimal Sac
Inferior Lacrimal Gland
Nasolacrimal Duct
Ducts of Lacrimal Gland
Lower Duct
Mouth of Duct (In Nose)

LACRIMAL APPARATUS

HO 2

# Anatomy of the Ear


Incus
Stapes
Malleus
Ossicles
Auricle
Semicircular
Canals
Nerve Pathways
to the brain
Cochlea
Eustachian Tube
Eardrum
Oval Window
External Auditory
Meatus

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT V : FUNCTIONAL SIGNIFICANCE OF COMMON HEALTH PROBLEMS

SCOPE OF UNIT:

This unit deals with definitions and identifies clinical problems of major disease groups commonly found in the long-term care population.

INFORMATION TOPIC: V-1 OR DEMONSTRATION:

PATHOLOGY OF LONG-TERM CARE RESIDENTS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe the motor, sensory, language, and behavior problems that may occur following a stroke or head injury.
2. Distinguish the functional differences between a paraplegic and a quadriplegic.
3. Identify the possible symptoms associated with Alzheimer's disease, Parkinson's disease, and multiple sclerosis.
4. Identify one physical sign for each type of arthritis.
5. Describe five common problems associated with diabetes.
6. Name four characteristic symptoms of chronic obstructive pulmonary disease.
7. Explain how each disuse phenomena can occur.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Characteristics of Strokes
2. TM 2: Characteristics of Quadriplegics
3. TM 3: Characteristics of Paraplegics
4. TM 4: Characteristics of Arthritis

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Lewis, Carole Bernstein. Aging: The Health Care Challenge. Philadelphia: F.A. Davis Company, 1985.

Lewis, Sandra Cutler. The Mature Years. Thorofare, NJ: Slack Incorporated, 1979.

INTRODUCTION:

Statistics indicate that 86% of older persons have some form of chronic health problem. Since most older people experience at least two chronic diseases simultaneously, it is essential that the restorative aide acquire a clear understanding of the diseases most prevalent among them.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT V : FUNCTIONAL SIGNIFICANCE OF COMMON HEALTH PROBLEMS

OUTLINE: (Key Points)

I. Brain Injury

  A. Stroke/CVA - caused by a blocked artery, blood clot, or broken blood vessel (TM 1) (II-1)

    1. Muscle paralysis of one side of the body; may also exhibit spasticity or flacidity; affects eating, completing self-care, and ambulation

       **NOTE: If the resident has a right CVA, the left side of his/her body will be affected. If the resident has a left CVA, the right side of his/her body will be affected.**

    2. Sensation may be impaired on the involved side

      a. Perception of pain, heat, and cold is diminished.

      b. Person may neglect or ignore the involved side.

      c. Visual fields may be limited (i.e., peripheral vision).

      d. Perception of position in space may be affected.

    3. Speech and language problems - usually associated with left CVA

      a. Aphasia - language disorder caused by brain damage; may result in deficits in areas of:

        1) Comprehension of what is said

        2) Verbal expression

        3) Reading and writing

      b. Apraxia - difficulty in the brain's ability to pass on the message of movement to the proper body parts (i.e., jaw, tongue, and lips, in an effort to produce speech)

c. Dysarthria - speech which is hard to understand due to muscle weakness

4. Nervous system is damaged

a. Sense of balance may be poor

b. Adjusts poorly to changes in routine

c. Requires short activity periods and frequent rest periods; more easily fatigued

5. Emotional sensitivity is possible

a. Dealing with disability

b. Dealing with uncontrolled emotional lability

B. Traumatic head injury - brain damage which occurs due to a severe blow to the skull; resulting loss of function is variable

1. Resident may exhibit muscle, sensory, and language problems similar to the person who has had a stroke.

2. Level of alertness may be diminished; short attention possible.

3. Ability to concentrate, follow directions and remember may be a problem.

4. Possible amnesia

II. Spinal Cord Injury (SCI) - is damage to the cord and nerves within the spinal column, due to a traumatic accident or disease; control of body functions is absent below the level of injury

A. Quadriplegia (TM 2)

1. Legs are paralyzed; resident is wheelchair bound and needs help in transferring.

2. Arm and hand motion are limited; will need assistance in daily activities.

3. Respiratory functions are diminished; may need assistance to cough.

4. Ability to communicate and think is normal.

5. Incontinence of bowel and bladder; may have an established bowel and/or bladder program.

6. Lack of sensation and inability to shift body weight can lead to decubitus ulcers.

7. Unable to regulate body temperature due to central nervous system damage.

B. Paraplegia (TM 3)

1. Resident is wheelchair-bound due to paralysis of legs.

2. Displays the same problems as the quadriplegic except hands and arms are not affected.

3. Should require little assistance for daily activities.

III. Progressive Diseases

A. Alzheimer's disease is deterioration of the brain caused by scarring (or plaques) and tangles in the structure of the brain.

1. Gradual decline in intellectual functions (i.e., memory, learning, reasoning, and judgment)

2. Language and motor impairments become evident over time (i.e., confusing speech and difficulty with reading and writing).

3. Personality changes and inability to control emotions is common (i.e., apathy - lack of interest, easily frustrated, irritable and at times hostile and combative).

4. Tendency to wander

5. In later stages

   a. Incontinence of bowel and bladder

   b. Nonambulatory

   c. Dependence in self-care

B. Parkinson's disease - a chronic degenerative disease of the nervous system caused by a chemical imbalance in the brain

1. Gradual loss of physical mobility - ambulation may be unsafe

   a. Muscles become rigid

   - b. Stooped posture
   - c. Poor balance
   - d. Involuntary tendency to take short accelerating steps

2. Oral-motor functions deteriorate (II-4)
   - a. Speech becomes slurred, monotone, and/or in short rushes with inappropriate silences.
   - b. Drooling
   - c. Swallowing difficulties due to inabilty of swallowing muscles and valves to contract

3. Intention tremor and poor fine motor control makes self-care tasks difficult.

4. Respiratory system is affected as the disease progresses; possible pneumonia.

5. Mental changes may include irritability, depression, and dementia.

C. Multiple sclerosis is caused by scarring and disruption of nerves in the brain and spinal cord; generally affects young adults; no known cause or cure

1. Location of damage in the nervous system determines a person's physical limitations.

2. Spastic weakness of all four limbs; resident may be wheelchair-bound; dysarthria due to muscle weakness

3. Resident may complain of numbness, tingling, or "pins and needles" feelings.

4. Vision is affected (i.e., blurring, blind spots, seeing double, and rapid alternating eye movements).

5. Other signs of brain impairment which require supervision of resident to insure safety
   - a. Loss of memory
   - b. An unrealistic feeling of well-being
   - c. Dementia

6. Often chronic bladder or urinary tract problems; incontinence of bowel and bladder may result.

7. Resident's emotional state can cause fluctuation in performance of daily activities.

8. Speech problems include difficulty controlling loudness and articulation of speech.

IV. Arthritis - chronic joint disease of one or more joints (TM 4) (II-5)

A. Three major types

1. Osteoarthritis

a. Degenerative joint disease (DJD) affects hips and knees.

b. Pain, muscle weakness, and movement limitations are present.

c. Caused by wear and tear on weight-bearing joints.

2. Rheumatoid arthritis (RA)

a. Inflammation, swelling of small joints (i.e., hands, feet, ankles, wrists) usually seen bilaterally

b. Complaints of stiffness and pain upon rising in the morning are common; loss of sensation and muscle strength are possible.

c. Serious deformities of joints often develop.

3. Gout

a. Recurring attacks of acute painful swelling in various joints (i.e., big toe or elbow)

b. Commonly seen in men

c. Caused by an increase in uric acid in the blood

V. Diabetes Mellitus

A. Condition which occurs when the body is unable to metabolize carbohydrates; carbohydrates accumulate and result in increased level of blood sugar due to insulin deficiency

B. Common problems associated with diabetes

1. Repeated infections

2. Visual impairments

a. Early cataracts

b. Diabetic retinopathy - blood clots obstruct light rays to retina and damage the retina itself

3. Peripheral neuropathy

a. Nerve damage in the limbs

b. Loss of sensation

c. Muscle weakness, atrophy, incoordination

4. Heart disease

5. Peripheral vascular disease

a. Poor circulation to the limbs

b. Coupled with nerve damage, can lead to gangrene, possibly amputation

VI. Chronic Obstructive Pulmonary Disease (COPD)

A. Causes resident to have difficulty moving air in and out of the lungs because airways are narrowed by spasms, secretions, or loss of elasticity of lung tissue

B. Types

1. Pulmonary emphysema

a. Constriction of small passages and blood vessels

b. Decrease in amount of air going into lungs

2. Chronic bronchitis

a. Excessive mucus production

b. Seen as a chronic cough and production of sputum

3. Bronchial asthma

  a. Hypersensitivity to various stimuli

  b. Bronchospasms cause reversible airways to narrow

C. General characteristics of COPD

  1. Barrel chest

  2. Shortness of breath upon exertion, decreased physical tolerance

  3. Chest pain

  4. Noisy respiration

  5. Apprehension/fear of movement

  6. Voice problems - hoarseness, inability to walk and talk simultaneously

VII. Disuse Phenomena - prolonged inactivity without preventative intervention can create secondary complications

A. Decubitus ulcers

  1. Cell death of skin and soft tissue due to prolonged pressure on blood vessels providing nutrients to the skin

  2. Occurs in bedridden and paralyzed residents

B. Muscle atrophy

  1. Shrinking of muscle due to lack of nerve supply to muscle or lack of active muscle contraction

  2. Disuse atrophy can be prevented by range of motion exercises.

C. Joint contractures

  1. Soft tissue surrounding a joint shortens due to decreased range of motion.

  2. May require surgical repair

D. Phlebothrombosis

   1. Usually occurs in legs

   2. Lack of motion causes circulatory system slow-down which in turn causes a vascular blockage or blood clot.

E. Pneumonia

   1. Decreased vital capacity

   2. Fluid build-up in lungs causes congestion, leads to infection.

F. Psychological deterioration

   1. Seen as loss of appetite, decreased dialog, and lethargy

   2. Resident seems to have "lost the will to live."

VIII. Summary and Conclusion

A. Brain injury

B. Spinal cord injury

C. Progressive diseases

D. Arthritis

E. Diabetes mellitus

F. Chronic obstructive pulmonary disease

G. Disuse phenomena

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT V : FUNCTIONAL SIGNIFICANCE OF COMMON HEALTH PROBLEMS

INTERACTION ITEMS:

1. What types of functional problems may develop due to impaired sensation or neglect of one side of the body?
2. Why is there such variance in post-brain injury residents with regard to muscle, sensory, and language functions?
3. Why is the quadriplegic prone to developing decubitus ulcers?
4. How does rheumatoid arthritis differ from osteoarthritis?
5. Why does the person with Parkinson's disease develop swallowing problems?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT V : FUNCTIONAL SIGNIFICANCE OF COMMON HEALTH PROBLEMS

EVALUATION ITEMS:

1. A stroke can cause: (Circle the letter of the correct answer.)

   a. Muscle paralysis of both legs
   b. Respiratory complications
   c. Poor sensation on one side of the body
   d. Inflammation of joints in the hand

_____ 2. If the resident experiences a right CVA, the right side of his/her body will be affected. (Write "T" if this statement is true, or "F" if it is false.)

For each symptom listed below, write "P" if seen most often in **paraplegia**, "Q" if seen in **quadriplegia** and "B" if common to both.

_____ 3. Incontinent of bowel and bladder

_____ 4. Arms are weak

_____ 5. Wheelchair bound

_____ 6. Usually independent in self-care

_____ 7. Legs are paralyzed

_____ 8. Prone to decubitus ulcers

9. Symptoms of Parkinson's disease includes: (Circle the letter of the correct answer.)

   a. Poor balance, tremor, mental changes
   b. Joint pain, swelling, tremor
   c. Blurred vision, incontinence, spasticity
   d. Sensory loss, poor balance, tremor

10. Rheumatoid arthritis involves: (Circle the letter of the correct answer.)

   a. Wear and tear of weight-bearing joints
   b. Acute swelling of the big toe
   c. Inflammation and swelling of small joints
   d. Pain in hips and knees

11. List four common problems associated with diabetes.

a.

b.

c.

d.

12. Chronic cough and production of sputum are associated with: (Circle the letter of the correct answer.)

a. Chronic bronchitis
b. Bronchial asthma
c. Pulmonary emphysema
d. Barrel chest

Match each symptom listed below to the condition that is associated with it.

____ 13. Poor blood circulation

____ 14. Skin neurosis

____ 15. Atrophy

____ 16. Poor vital capacity

____ 17. No active muscle contractions

a. Pneumonia

b. Shrinking muscle

c. Decubitus ulcers

d. Phlebothrombosis

e. Contractures

LESSON PLAN: - 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT V : FUNCTIONAL SIGNIFICANCE OF COMMON HEALTH PROBLEMS

ANSWERS TO EVALUATION ITEMS:

1. c
2. F
3. B
4. Q
5. B
6. P
7. P
8. B
9. c
10. c
11. a. Infections
    b. Visual problems
    c. Peripheral neuropathy
    d. Vascular disease
12. a
13. d
14. c
15. b
16. a
17. e

TM 1

# Characteristics of Strokes

A. Paralysis on one side (from midline of body)

B. May have speech and/or language problems

   1. Difficulty understanding what you say

   2. Difficulty saying what he/she wants to say

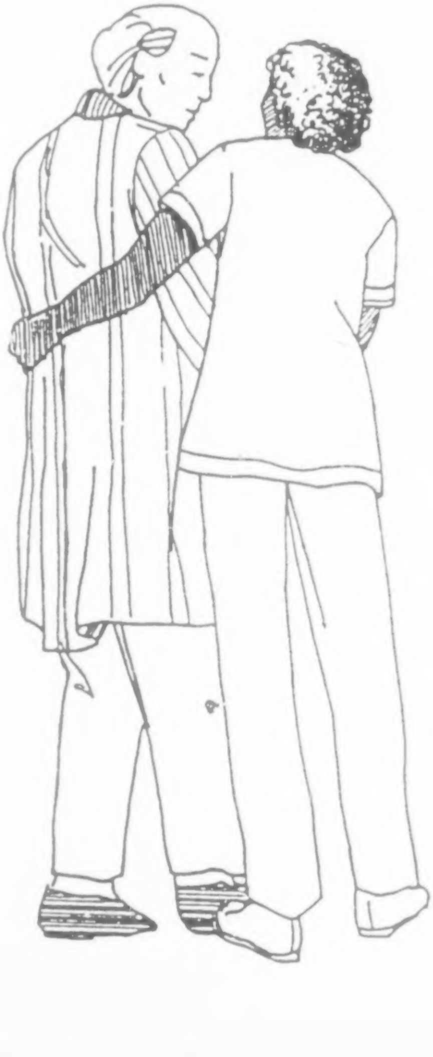
   3. Slurring words due to muscle impairment

C. Face droops on involved side

D. May not realize involved side belongs to him/her

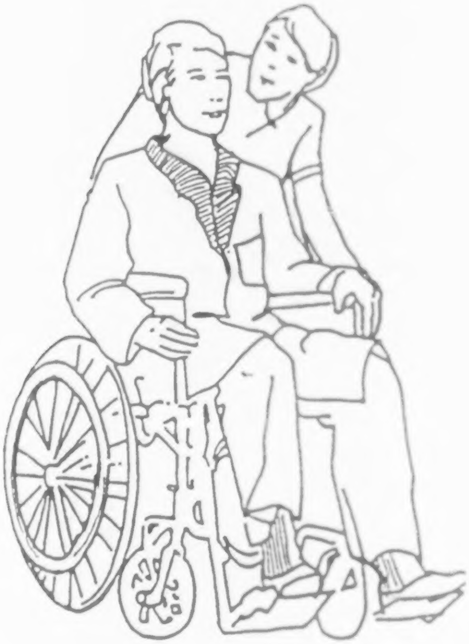
E. Sensation may be lost on involved side, may not know where involved arm or leg is

F. Usually, but not always spastic



TM 2

# Characteristics
## of Quadriplegics



A. All four extremeties involved, uppers not usually completely paralyzed

B. Will probably be spastic

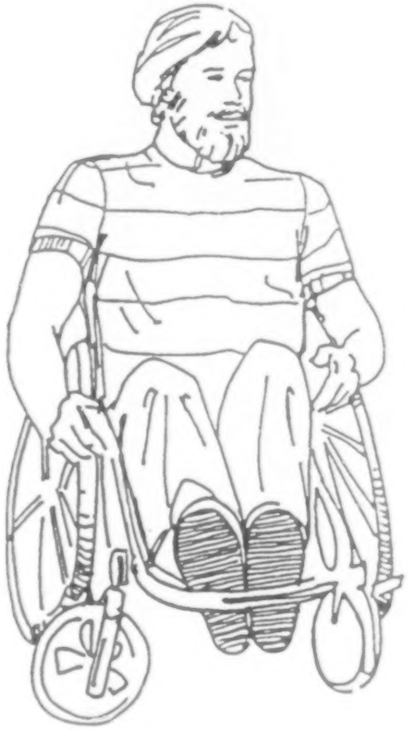
C. If complete injury to cord the resident will be confined to a wheelchair

D. May have respiratory problems (cough and sneeze) due to loss of abdominal muscles

E. May have tracheostomy (especially early on)

# Characteristics

## of Paraplegics



A. Two extremities involved, usually lower

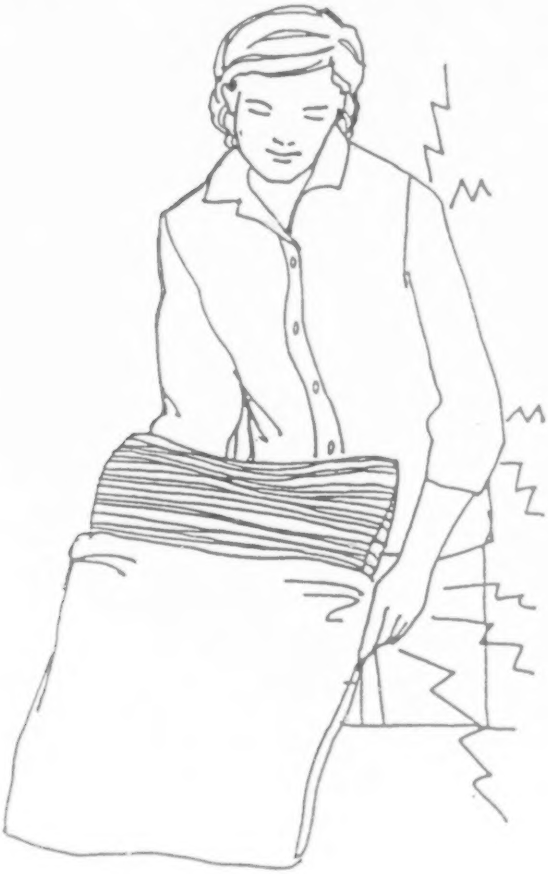
B. Upper extremities normal

C. Whether or not the resident can learn to walk with braces and crutches depends upon the level of cord injury

D. May be flaccid or spastic

E. If a complete cord injury, the resident will not return to normal

# Characteristics
## of Arthritis



1. Means inflamation of a joint or joints
2. May be painful upon motion
3. Causes deformity in some cases

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletel limitations such as contractures, muscle weakness, and incoordination will also be reviewed.

INFORMATION TOPIC: VI-1 OR DEMONSTRATION:

COGNITIVE LOSS AND MEMORY IMPAIRMENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List two basic cognitive skills.
3. Identify typical cognitive losses which may occur because of a disability.
4. Identify the four types of memory.
5. Describe how institutionalization contributes to memory loss.
6. List two physical disabilities that typically result in memory loss.
7. List two ways the RNA can assist the resident in improving functional levels of cognition and memory.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Crepeau, Elizabeth L. Activity Programming for the Elderly. Boston: Little, Brown, and Co., 1986.

INTRODUCTION:

There are many assumptions about older people's ability to think, learn, and remember. Most have no factual basis. This lesson will clarify the terms memory and cognition and explain the most common types of impairments seen in the LTC population. It is important to note that it is the RNA who provides the adaptations that need to be made to facilitate learning for the older resident.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Attention span - focusing on a task for a particular length of time

  B. Cognition - performance of mental skills required to comprehend and understand

  C. Generalization - applying previously learned concepts to a variety of situations

  D. Memory - ability to retain and recall tasks or concepts

II. Cognition

  A. Defined as the performance of mental skills required to comprehend and understand

  B. Types of cognitive skills

    1. Basic cognitive skills

      a. Include orientation, attention span, memory, decision making, sequencing, following directions

      b. Without the basic cognitive skills, learning ability is impaired.

    2. Higher level cognitive skills

      a. Generalization

      b. Problem solving

  C. Cognitive skills work together to allow a person to do complicated tasks such as drive a car or balance a checkbook. (II-1)

III. Cognitive Loss

  A. Normal, age-related changes are minimal.

    1. Reaction time slows.

2. Learning rate slows due to cautiousness and fear of failure. (II-2)

B. Typical losses due to disabling conditions

1. Mood swings (lability) - changing from one emotion to another without reason

2. Inability to concentrate or attend to a task; may be mistaken for impatience

3. Unable to detect own errors and self-correct; may be labelled "careless"

4. Confusion and disorientation

5. Poor sequencing of steps to do a simple task; may be mistaken for dependent behavior

6. Unable to monitor own behavior; can be viewed as immature actions or impoliteness

7. Difficulty initiating action

IV. Memory

A. Defined as the ability to retain and recall tasks or concepts; a cognitive skill

B. Four types of memory (II-3)

1. Short-term - immediate recall after a span of 5 to 30 seconds
Example: Remembering a number read from the telephone directory long enough to dial

2. Recent - recall after one hour to one week
Example: Remembering what you ate for breakfast

3. Remote - recalling events from the past which involved repeated rehearsal of information over a long period of time
Example: Reciting a nursery rhyme learned as a child

4. Old memory - recalling past events that have not been thought of since
Example: Seeing an old photograph and remembering an experience

V. Memory Loss

A. Normal, age-related changes are minimal; usually limited to recent memory and retrieval of information stored in the memory.

B. Institutionalization contributes to memory loss in requiring adjustment to a new schedule, people, and environment; memory skills are not practiced.

1. Decreased stimulation

2. Less expectations for performance

3. Restrictive environment

(II-4).

C. Physical illness, particularly damage to the central nervous system, creates low energy level, limited interactions with the environment; leads to confusion

1. Parkinson's disease

2. Post-CVA

3. MS

4. Traumatic head injury

5. Alzheimer's disease

VI. How Cognitive/Memory Loss Affects Functional Independence

A. Resident who lacks basic cognitive skills (attention span, orientation, or memory) will always need assistance in ADL; rehabilitation potential is poor (II-5)

B. Limited short-term and recent memory will make it difficult to learn new things, such as how to call for the nurse or find the way to the bingo game.

C. Fluctuations in cognitive level (a resident who is lucid one moment and confused the next) can lead to unsafe situations; resident requires supervision.

D. RNA can assist the resident in improving functional levels of cognition and memory.

1. Simplify the environment.

2. Use one-to-one training in compensatory techniques with repetitive practice.

## VII. Summary and Conclusion

A. Terms and definitions

B. Cognition

C. Cognitive loss

D. Memory

E. Memory loss

F. How cognitive/memory loss affects functional independence

You have learned that memory is only one of the many cognitive skills used automatically in daily activities. Changes in thought processes due to normal aging, environment, and physical illness are present in the LTC population and do affect the resident's ability to lead a satisfying and productive life. In a later lesson, you will be exposed to various techniques used to help the resident cope with such losses.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. What cognitive skills are required in using a vending machine? (ability to count/handle money, attention to task, decision making, following directions, sequencing)

2. Knowing these facts, how can you alter the learning environment to help the elderly resident? (Allow extra time, give continual feedback, be supportive)

3. Short-term memory (STM) is required in order to learn new things. How can we help the resident with STM loss learn to use a walker?

4. How can the environment be modified to reduce memory loss?

5. How can the task of getting dressed be affected by disorientation and a poor attention span?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the appropriate letter in the blank.

____ 1. Applying previously learned concepts to a variety of situations

____ 2. Focusing on a task for a particular length of time

____ 3. Performance of mental skills required to comprehend and understand

____ 4. Ability to retain and recall tasks or concepts

a. Cognition

b. Attention span

c. Generalization

d. Memory

5. List two basic cognitive skills.

a.

b.

Match the type of cognitive loss with the correct description by writing the letter in the blank.

____ 6. Mr. Jones swears when asking someone to pass the salt at dinner.

____ 7. Mrs. Swinson shows up for the activity outing wearing undergarments, skirt, stockings and shoes, but no blouse.

____ 8. When the activity volunteer introduced herself, Mrs. Smith cried uncontrollably.

____ 9. Mr. Ellis is asked to fold five towels. Two towels get folded, three remain in the basket. He leaves to sit in the lounge.

a. Poor sequencing

b. Inability to monitor own behavior

c. Lability

d. Poor attention span

Match the four types of memory listed below with their correct descriptions.

____10. Recall after one hour to one week

____11. Recalling events from the past which involved repeated rehearsal of information over a long period of time

____12. Recalling past events that have not been thought of since

____13. Immediate recall after a span of 5 to 30 seconds

a. Remote memory

b. Short-term memory

c. Old memory

d. Recent memory

14. Describe how institutionalization contributes to memory loss.

15. List two physical disabilities that typically result in memory loss.

    a.

    b.

16. List two ways the RNA can assist the resident in improving functional levels of cognition and memory.

    a.

    b.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. c
2. b
3. a
4. d
5. The student may list any two of the following:
    a. Orientation
    b. Attention span
    c. Memory
    d. Decision making
    e. Sequencing
    f. Following directions
6. b
7. a
8. c
9. d
10. d
11. a
12. c
13. b
14. Institutionalization contributes to memory loss in requiring adjustment to a new schedule, people, and environment; memory skills are not practiced
        1. Decreased stimulation
        2. Less expectations for performance
        3. Restrictive environment
15. The student may list any two of the following:
    a. Parkinson's disease
    b. Post-CVA
    c. MS
    d. Traumatic head injury
    e. Alzheimer's disease
16. a. Simplify the environment
    b. Use one-to-one training in compensatory techniques with repetitive practice

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletel limitations such as contractures, muscle weakness and incoordination will also be reviewed.

INFORMATION TOPIC: VI-2 OR DEMONSTRATION:

## SENSORY LOSS AND COMPENSATION ISSUES

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define self-image.
2. Identify the implications of sensory loss on rehabilitation potential.
3. List examples of functional skills affected by sensory loss.
4. List four techniques which can be taught to the resident to compensate for sensory loss.
5. List four measures the RNA can take to help the resident compensate for sensory loss.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Compensation Techniques

### INFORMATIONAL ASSIGNMENT: (Student)

**Refer to Unit IV, Lesson 4 to review typical sensory losses of the LTC resident**

### REFERENCES: (Instructor's Additional Information)

Lewis, Carole Bernstein. Aging: The Health Care Challenge. Philadelphia: F.A. Davis, 1985.

Hurley, Olga. Safe Therapeutic Exercise for the Frail Elderly. New York: New York Center for Study of Aging, 1988.

Shore, J. (1976). "Designing a Training Program for Understanding Sensory Loss in Aging." Gerontologist, 16(157).

### INTRODUCTION:

**Sensory losses affect the functioning of the long-term care residents and limit them from receiving stimuli from the world around them. Vision, taste and odor discrimination, and the sense of touch are senses we often take for granted and can't imagine being without. A solid understanding of the typical problems and options for compensation will prove invaluable to you in your daily practice.**

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Self-image - how one views himself/herself in relation to others

  B. Sensory stimulation - focusing the resident's attention to each of his/her senses; used to treat sensory, cognitive, perceptual problems

II. Sensory Loss and Rehabilitation Potential

  A. Many times the resident who is labled "confused" is, in fact, experiencing sensory loss.

    1. Resident misinterprets sensory input + inaccurate processing of input = inaccurate response; often judged as "confused."

    2. Confusion and disorientation increase with more than one sensory loss.

  B. Motor control or coordination cannot be fully regained when tactile sensation is impaired.

  C. Safety precautions required to prevent injury (II-3)

    1. Small scratches or wounds can become infected; pressure sores can develop quickly and become infected.

    2. Insensitive arms/legs are more prone to injury from neglect.

    3. Desirable temperatures should be maintained.

      a. Handling soups/beverages

      b. Soft lining of mouth and digestive tract may be burned by eating/drinking a food/beverage that is too hot.

      c. Temperature of bath/shower water should be tested before resident bathes/showers.

    4. Cues of danger in environment may be meaningless.

5. Evaluate the living and treatment areas for potential hazards and eliminate them.

D. Functional ability will be significantly impaired

1. Visual deficits influence daily activities and ambulation. (II-4)

2. Tactile and/or visual impairments cause loss of functional skills required to control the environment and perform self-care. EXAMPLES:

    a. Difficulty locating/manipulating light switches/call button

    b. Back fasteners on clothing such as zippers and buttons not easily managed, if at all

    c. Locating bed covers at night is difficult

    d. Accidental voiding may go unnoticed, causing skin irritation

    e. Hygiene and grooming tasks are difficult to accomplish

    f. Pocketing of food in mouth is common with sensory impairment

3. Altered taste and smell of foods may discourage resident from eating.

E. Self-image and ability to interact with others may be impaired (II-5)

1. Confusion/disorientation

2. Social isolation/appearance of senility

3. Dependent on others to provide correct sensory information

III. Compensation Techniques

A. When sensory loss cannot be restored, activities once done automatically must now be brought to the conscious level; requires more physical and mental energy.

B. Techniques taught to resident

1. Vision is a substitute for touch sensation if attention is adequate.

    a. Visually search for body parts while bathing.

b. Check skin often for irritation and/or bruising.

c. Properly position insensitive arm or leg.

2. Evaluate and seek assistance to modify environment to eliminate potential hazards (hot items) and barriers.

3. Assertiveness to ask for assistance or to clarify sensory information

C. Measures the RNA can take to help resident compensate and promote independence (HO 1) (II-6)

**NOTE: Refer to handout 1 for additional compensation techniques the RNA can use. Discuss them in class.**

1. Allow more time for task completion.

2. Continually use verbal cues.

3. Use touch as a means of communication.

4. Evaluate the immediate environment for potential hazards and barriers and notify the immediate supervisor or consultant of their existence; help modify environment to enhance resident's functional level.

5. Include sensory stimulation in all aspects of your interaction with the resident.

6. Emphasize the social aspects of groups. Encourage resident to express his/her difficulties.

IV. Summary and Conclusion

A. Terms and definitions

B. Impact of sensory loss on rehabilitation potential

C. Compensation techniques

The impact of sensory loss on quality of life cannot be overemphasized. A resident's potential for interaction with his/her surroundings is highly dependent on his/her capacity to receive and to respond to information obtained through the eyes, nose, mouth, and skin.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. What daily problems might be noted when a resident is unable to taste accurately?
2. In which disabilities do we commonly see tactile sensory loss?
3. What extra safety precautions should be taken when working with a resident who has a sensory deficit?
4. Why would a sensory deficit decrease a resident's ability to take care of himself/herself?
5. How might impaired sensation affect a person's self-image?
6. What can the RNA do to promote the resident's level of independence?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Role-play resident and RNA in the following situations:

1. Resident with impaired taste and smell along with poor nutritional status at lunchtime
2. Resident with poor sensation is being instructed in bathing technique on right side of body
3. Resident with decreased vision wishes to dress himself/herself

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

1. Define the term "self-image."

For each of the following possible implications of sensory loss on rehabilitation potential, mark "T" if the statement is true, or "F" if it is false.

____ 2. A resident who responds inappropriately and acts confused in certain situations may be exhibiting behavior resulting from sensory loss, not impaired mental status.

____ 3. If more than one sensory loss is experienced by a resident, it is likely that confusion and disorientation will increase.

____ 4. Even though the tactile sense is impaired, the resident can almost always regain motor control and coordination within a short time.

____ 5. The resident with sensory loss is at no greater risk of injury than the average person.

____ 6. A resident with sensory loss could unknowingly swallow food that is hot enough to burn the inside of the mouth.

____ 7. Residents with sensory loss may not be able to perceive cues of danger in the environment.

8. List three examples of functional skills which are affected when a tactile or visual sensory loss is present.

   a.

   b.

   c.

9. List four compensation techniques which can be taught to the resident.

   a.

   b.

   c.

   d.

10. List four measures the RNA can take to help the resident compensate for sensory loss.

   a.

   b.

   c.

   d.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. How one views himself/herself in relation to others
2. T
3. T
4. F
5. F
6. T
7. T
8. The student may list any three of the following or other examples that meet with the instructors approval:
    a. Difficulty locating/manipulating light switches/call button
    b. Back fasteners on clothing such as zippers and buttons not easily managed, if at all
    c. Locating bed covers at night is difficult
    d. Accidental voiding may go unnoticed, causing skin irritation
    e. Hygiene and grooming tasks are difficult to accomplish
    f. Pocketing of food in mouth is common with sensory impairment
9. The student may list any four of the following:
    a. Vision will substitute for touch sensation if attention is adequate
        1) Visually search for body parts while bathing.
        2) Check skin often for irritation and/or bruising.
        3) Properly position insensitive arm or leg
    b. Evaluate and seek assistance to modify environment to eliminate potential hazards (hot items) and barriers
    c. Assertiveness to ask for assistance or to clarify sensory information
10. The student may list any four of the following:
    a. Allow more time for task completion.
    b. Continually use verbal cues.
    c. Touch as a means of communication
    d. Evaluate the immediate environment for potential hazards and barriers and notify the immediate supervisor or consultant of their existence; help modify environment to enhance resident's functional level
    e. Include sensory stimulation in all aspects of your interaction with the resident.
    f. Emphasize the social aspects of groups. Encourage resident to express his/her difficulties.

HO 1

# Compensation Techniques

| Functional Loss | Compensation |
|---|---|
| Taste/Smell | Signals other than smell can be used to indicate mealtime. |
| | The social aspects of eating should be encouraged. |
| | Suggest use of herbs and spices to enhance foods which may be bland. Choose of foods with a variety of texture. |
| | Make food more visually appealing. |
| | Practice good oral hygiene to increase taste acuity. |
| | Personal cleanliness should be encouraged, to prevent unpleasant body odors. |
| Touch | Visual cues such as marking hot/cold faucets clearly. |
| | Rough textures on hall and stair handrails. |
| | Reinforce and provide feedback to make resident aware of sensory limitation. |
| | Educate resident to be alert to reddened skin as a sign of excessive pressure. |
| | Use physical contact in conversation. |
| | Use a bath thermometer. |
| | Teach resident to be alert to foods that retain heat. |
| | Avoid sudden unexpected changes in body position in space. |
| | Allow sufficient time after he/she has changed positions (i.e., standing from sitting, walking). |

| Functional Loss | Compensation |
|---|---|
| Vision | Color contrast enhances visual acuity, depth perception, color discrimination. |
| | Orange, yellow, and red stand out better than blue, green, or violet. |
| | Mark on/off switches with red tape. |
| | First and last steps in stairway should be differentiated from others by color contrast. |
| | Fiber tip pens are easier to read than ink pen or pencil writings. |
| | Magnifiers with battery powered illumination serve many uses. |
| | Avoid abrupt changes in light; take measures to reduce glare. |
| | Use touch in communication. |
| | Provide adequate light. People with visual problems need much more light than the average person. |

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletal limitations such as contractures, muscle weakness, and incoordination will also be reviewed.

INFORMATION TOPIC: VI-3 OR DEMONSTRATION:

## APRAXIA AND APHASIA
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define apraxia.
2. Identify guidelines for dealing with the resident with apraxia.
3. Identify ways apraxia can affect the resident's daily life.
4. Define aphasia.
5. Identify measures which the RNA should take to help the aphasic resident.
6. Identify ways aphasia can affect the resident's daily life.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Communicating with the Aphasic Resident

INFORMATIONAL ASSIGNMENT: (None)

REFERENCES: (Instructor's Additional Information)

Aphasia and the Family. Dallas, TX: American Heart Association, 1969.

Bollinger, R.L., et. al. Communication Management of the Geriatric Patient. Danville: The Interstate Printers and Publishers, 1977.

Schow, R.L., et. al. Communication Disorder of the Aged: A Guide for Health Professionals. Baltimore: University Park Press, 1978.

INTRODUCTION:

Imagine that you suddenly awake and find that you can't understand what people are saying to you. Words written on paper look foreign to you. You try to write your name and you can't remember how to spell it. Every time you try to say something it comes out all wrong and everyone gives you puzzled looks. Worse yet, you try to do a simple task such as combing your hair and instead of getting the comb to your head, it goes to your face. These are only some of the symptoms you might experience if you suddenly had a stroke or brain injury which left you with aphasia and apraxia. In this lesson we will be discussing symptoms of aphasia and apraxia as well as the impact of these disorders on rehabilitation potential.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Anomia - inability to recall words

  B. Aphasia - language disorder resulting from damage or disease of the brain

  C. Apraxia - a motor planning problem; inability to perform certain skilled, purposeful movements even though motor power, sensation, and coordination may be normal

  D. Perseveration - inability to stop a certain behavior

II. Apraxia

  A. Defined as difficulty with movement (i.e., the brain can't tell the body how to move)

  B. Caused by stroke, brain tumor, or head injury

  C. Can affect speech and/or any movement of the body; can range from mild to severe problem

  D. Impact on resident's everyday life

    1. Mild: Difficulty pronouncing some words

       Severe: Lengthy struggle to utter nonsense sounds

    2. Mild: Slowness in completing unfamiliar activities

       Severe: Unable to bring hand to mouth in order to feed self (II-2)

    3. Mild: Unable to regain ability to whistle or move tongue in a purposeful way

       Severe: Difficulty swallowing or moving food around in mouth

4. May also have difficulty doing exercises, walking, maneuvering a wheelchair, drawing, or other daily skills

E. General guidelines for dealing with residents who are apraxic (the therapy consultant will show you techniques for a resident's specific limitations)

1. Allow resident plenty of time to respond.

2. Be patient.

3. Ask questions requiring one- or two-word answers.

4. Use automatic or familiar activities to promote successful experience.

5. Guide the arm or leg in desired motion. Give sensory input such as firm pressure or rubbing. (II-3)

6. Repetition of motion

7. Be supportive of resident when he/she becomes frustrated.

III. Aphasia

A. Defined as a language disorder resulting from brain damage

B. Caused by stroke, brain tumor, or head injury

C. Language abilities are much poorer than intellectual abilities, therefore aphasia is not attributable to dementia, confusion, sensory loss, or motor impairments.

D. Possible problems

1. Perseveration - inability to stop saying a certain word or phrase

2. Anomia - inability to recall a word (II-4)

3. Difficulty understanding your words

4. Can't tune out distracting noises (II-5)

5. May not be able to read or write, or copy letters or shapes

E. Impact on resident's daily life

1. Need instructions presented at a slower rate of speech
2. Need gestures or visual cues to understand what you are saying
3. Able to process only short sentences
4. Need repetition - saying the same thing in different ways (i.e., the chair - what you sit on)
5. May have trouble responding to questions or telling you his/her needs.
6. Not a reliable informant
7. Need a warning signal before receiving information (i.e., "Mr./Mrs. Smith, I'm going to tell you something. Are you ready?")

F. General guidelines for working with the resident with aphasia (therapy consultant will show you techniques for resident's specific limitation) (HO 1)

**NOTE: Handout 1 lists additional measures for communicating with the aphasic resident. Discuss them in class.**

1. Give the resident time to respond.
2. Repeat the message back. (II-6)
3. Use familiar words in short, clear sentences.
4. Use gestures and facial expressions (nonverbal communication techniques) in addition to your words.
5. Provide written and verbal cues.
6. Be familiar with resident's level of comprehension and adjust rate, length, and complexity of speech.
7. Do not assume the language impairment means confusion, disorientation, or deafness.

IV. Summary and Conclusion

A. Terms and definitions

B. Apraxia

## C. Aphasia

When working with individuals who are suffering from aphasia and/or apraxia, it is necessary to understand exactly why they act the way they do in order to give them the very best care possible. Learning to communicate effectively with aphasic and apraxic residents can be quite a challenge, but it can also be very rewarding to see the progress they can make. In this lesson we have explored causes and characteristics of these disorders as well as their impact on the rehabilitation process.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. Can you recall a resident with whom you have worked in the past who showed signs of a motor planning problem?
2. What kind of motor planning is necessary when brushing your teeth?
3. How could this be done when working on arm strengthening exercises?
4. How do you feel when you have difficulty expressing a thought because you momentarily can't think of the exact word(s) you want to say?
5. How could this impact on daily life? What would be the effects with regard to progress in therapy?
6. Why is verbal feedback so important?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

1. Apraxia can be defined as: (Circle the letter of the best answer.)

   a. A motor planning problem
   b. A speech problem
   c. Poor motivation
   d. A psychological problem

2. All of the following methods are good to use when working with the apraxic resident EXCEPT: (Circle the letter of the best answer.)

   a. Work quickly to keep his/her attention.
   b. Provide psychological support.
   c. Guide arm or leg in desired motion.
   d. Be patient.

For each of the following symptoms, mark "X" if it is associated with APRAXIA or "O" if it is associated with APHASIA.

____ 3. Can't maneuver the wheelchair from therapy to the dining room

____ 4. Word finding problems

____ 5. Difficulty swallowing

____ 6. Slowness in tying shoes

____ 7. Resident says "Open the window" when it is already open

____ 8. Problems walking in the parallel bars

____ 9. Resident puts the comb in her mouth when trying to comb her hair

____ 10. Resident is not a reliable informant

11. The RNA can help the aphasic resident to understand by: (Circle the letter of the best answer.)

   a. Adjusting rate, length, and complexity of speech
   b. Giving the person plenty of time to respond
   c. Using nonverbal communication
   d. All of the above

12. Which one of the following best defines aphasia? (Circle the letter of the best answer.)

    a. A disorder resulting from dementia
    b. A disorder resulting from muscle weakness
    c. A disorder resulting from disease or injury to the brain
    d. A disorder affecting motor programming

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. a
2. a
3. x
4. o
5. x
6. x
7. o
8. x
9. x
10. a
11. d
12. c

# Communicating
## with the Aphasic Resident

Aphasia - Language impairment, due to brain damage, which is manifested in deficits of listening, speaking, reading, and writing skills.

### Comprehension

Simplify
1. Handle only one idea at a time.
2. Use short sentences with simple, common words.
3. Use gestures, facial expressions, vocal inflections.

Allow Time
1. Pause between short sentences.
2. Slow down rate of speech and allow the resident time to process information.

Orient Resident
1. Discuss topics pertinent to familiar, relevant and personal aspects of the resident's life.
2. Orient resident to people, place, and time by pointing out and discussing people and items in the environment.
3. Keep resident aware of time of day via mealtimes, medications, and announcements of visitors and times they frequently come.

Confirm

Resident may respond to gestures or intonation without understanding you.
1. Ask resident question.
2. Allow resident to respond.
3. Ask resident opposite question; if resident responds the same to both questions, you are not communicating.
4. Be sure you have resident's attention.
5. Let resident know there was a misunderstanding.
6. Speak more slowly.
7. Repeat and/or reword message.
8. Use gestures, pointing, facial expressions. Don't speak more loudly if resident did not understand you. Confusion increases with added noise and distractions, and when more than one person is talking.

## Expression

### Allow Time

Be patient and accepting of resident's attempts to communicate.

### Guess

1. Determine the subject by asking more specific questions.
2. Make statements about what you think the resident means.

### Alternative Communication

1. Communication board
2. Gestural system - devise own nonverbal methods - encourage pointing gestures, head nod. If **you** use gestures when communicating with aphasic residents, this may stimulate their use of gestures.

### Verbal Communication

1. Ask questions requiring yes/no or one-word response.
2. With more verbal residents who have word-finding difficulties, encourage substitute ways of expressing meaning by asking questions like:
   "What do you use it for?"
   "Where is it?"
   "What does it look like?"
   "Why do you need it?"
3. When a resident does convey what he/she wants, in a way other than verbal, say the word for him/her.

### Respect

1. Speak to the resident in an adult manner; she/he is usually an intelligent adult who is quite aware of her/his surroundings even though language function is impaired.
2. Include the resident in the conversation; don't talk as though he/she is not there, deaf, or mentally retarded.

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LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletal limitations such as contractures, muscle weakness, and incoordination will also be reviewed.

INFORMATION TOPIC: VI-4 OR DEMONSTRATION:

DYSPHAGIA, DYSARTHRIA AND LARYNGECTOMY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in the lesson to correct definitions.
2. Identify diseases or injuries associated with dysphagia.
3. Identify the roles of members of the dysphagia team.
4. Identify areas of speech production which might be impaired with dysarthria.
5. Identify anatomical changes following a laryngectomy.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Anatomical Changes Following Laryngectomy

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia. Review Unit IV, Lesson 21, section VI entitled "Residents with Special Eating Problems."

REFERENCES: (Instructor's Additional Information)

Logemann, J. Evaluation and Treatment of Swallowing Disorders. San Diego: College-Hill Press, Inc., 1983.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

Steefel, J.S. Dysphagia Rehabilitation for Neurologically Impaired Adults. Springfield: Charles C. Thomas, 1981.

INTRODUCTION:

Our abilities to swallow and speak are so second nature that we can easily take them for granted. Many residents who have suffered illness/injury find that eating, swallowing, and speaking have become difficult. In this lesson we will discuss these problems, the roles of those involved in treatment of the resident, and particularly the role of the RNA in assisting the resident with the maintenance phase of his/her program.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Aspiration - the taking of anything into the lungs other than air (i.e., thin or thick liquids or solids)

   B. Dysphagia - difficulty swallowing

   C. Dysarthria - speech disorder resulting from muscle weakness secondary to damage to motor processes

   D. Imprecise - not exact

   E. Laryngectomy - surgical removal of the larynx

   F. Larynx - voice box; protects lungs from being penetrated by anything but air

   G. Oral - of the mouth

   H. Stoma - opening made in the neck exposing the trachea

   I. Videofluoroscopy - moving x-ray of the swallowing process which enables the physician and therapists to study all phases of the resident's swallowing and determine if patient is aspirating

II. Types of Dysphagic Residents and Their Characteristics

   A. Cerebral vascular accidents (CVA) - muscles of swallowing and swallow reflex may be weak

   B. Head injury - same as CVA

   C. Cerebral palsy - may display delayed swallowing or poor chewing

   D. Parkinson's disease - may have delayed swallow and general muscle weakness

   E. Amyotrophic lateral sclerosis (ALS - Lou Gehrig's disease) - muscles gradually lose function

   F. Multiple sclerosis (MS) - may have poor chewing and tongue control, as well as delayed swallow

G. Myasthenia gravis - the ability to swallow degenerates the more the resident swallows, however, it improves with rest

H. Residents who have had surgery for tongue, jaw, or neck cancer

I. Residents who have had certain types of laryngeal surgery

III. Dysphagia Team - the team approach is used in the management of residents with swallowing and chewing difficulties, and each member has a role (II-1)

A. Physician - makes a referral to a radiologist for a swallowing evaluation and prescribes treatment program for resident based on the findings of the radiologist and speech pathologist

B. Radiologist - performs video fluoroscopy with the resident's speech pathologist; reports findings to physician

C. Speech pathologist - assists with administration of the video fluoroscopy and assesses the possibility of behavior management of the swallowing impairment

D. Occupational therapist - evaluates resident's ability to use his/her hands, arms, and correct posture during eating; and determines if special spoon, sling, or other assistive devices would be beneficial to the resident

E. Nurse - reports resident's status and eating behavior

F. Dietician - plans special dysphagia diet or tube feedings to insure adequate nutrition

G. RNA - once the maintenance phase of swallowing has been reached, the RNA may be asked to (under the supervision of the speech pathologist) assist a resident in following his/her exact routine for achieving a successful swallow (II-2)

IV. Dysarthria - speech disorder resulting from muscle weakness due to disease or injury; depending on the location of the damage, residents may have one or more of the following characteristics: (II-3)

A. Impaired articulation

1. Distortions - sounds which are close to the target sounds but not entirely accurate

2. Imprecise consonants

3. Inability of the articulating muscles to function smoothly or harmoniously

B. Impaired prosody (intonation and stress of speech)

1. Monopitch - same pitch

2. Monoloudness - same loudness

3. Long, inappropriate pauses between words

4. Too slow a rate of speech

5. Too fast a rate of speech

6. Holding sounds too long

7. Stressing words inappropriately

C. Impaired phonation - producing voice

1. Inappropriate voice loudness

2. Inappropriate pitch

3. Harsh, strained vocal quality

4. Breathy voice

D. Impaired resonance

1. Nasal voice quality

2. Nasal emission of air - air being snorted through the nose when speaking

V. Laryngectomy - surgical removal of the larynx; commonly removed due to injury or cancer; anatomical changes which occur and necessitate care: (HO 1) (II-4)

A. Vocal cords have been removed. Producing speech by the use of vocal cords is no longer possible.

B. Resident will now breathe through an opening in the neck called a "stoma" which requires care and precautions.

VI. Summary and Conclusion

A. Terms and definitions

B. Types of disphagic residents and their characteristics

C. Dysphagia team - members of team and their roles

D. Dysarthria - areas of speech production which can be impaired

E. Laryngectomy - anatomical changes

NOTE: Additional information regarding laryngectomy and alternative communication methods can be found in Unit VII, Lesson Plan 9.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. Who are the members of the dysphagia team and what are their roles?

2. Discuss specifically the role of the RNA in dysphagia follow-up care.

3. What is dysarthria and how does it affect speech production?

4. How does a laryngectomy change a resident's anatomy?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Review the case histories of residents who have undergone rehabilitation for dysphagia, dysarthria, and laryngectomy (if possible).

Discuss specifically:

1. Cause of each person's disability (diagnosis)

2. Who was involved in rehabilitation, and how

3. Resident's response throughout treatment

4. Any recurring or ongoing problems or care that resident might be undergoing

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the appropriate letter in the blank.

____ 1. Moving x-ray of the swallowing process

____ 2. Speech disorder resulting from muscle weakness

____ 3. Difficulty swallowing

____ 4. Taking food or liquid into the lungs

____ 5. Voice box

____ 6. Of the mouth

____ 7. Surgical removal of the larynx

____ 8. Opening made in the throat (neck)

a. Larynx

b. Aspiration

c. Video fluoroscopy

d. Oral

e. Dysphagia

f. Dysarthria

g. Laryngectomy

h. Stoma

9. List six types of residents who may have dysphagia.

a.

b.

c.

d.

e.

f.

**Match the following staff members/consultants with their roles on the dysphagia team.**

____ 10. Plans meals for resident to insure proper nutrition

____ 11. Reports on resident's eating status on the floor

____ 12. Provides help with assistive devices needed for feeding (i.e., special spoon)

____ 13. Designs plan for swallowing therapy

____ 14. Makes referral for dysphagia evaluation

____ 15. Does video fluoroscopy with the speech pathologist

____ 16. Under supervision of speech pathologist may assist resident in following his/her exact routine for achieving swallow

a. Physician

b. Radiologist

c. Dietician

d. Nurse

e. Speech pathologist

f. Occupational therapist

g. RNA

17. List four areas of speech production which might be impaired with dysarthria.

a.

b.

c.

d.

18. List the two anatomical changes which occur following a laryngectomy.

a.

b.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

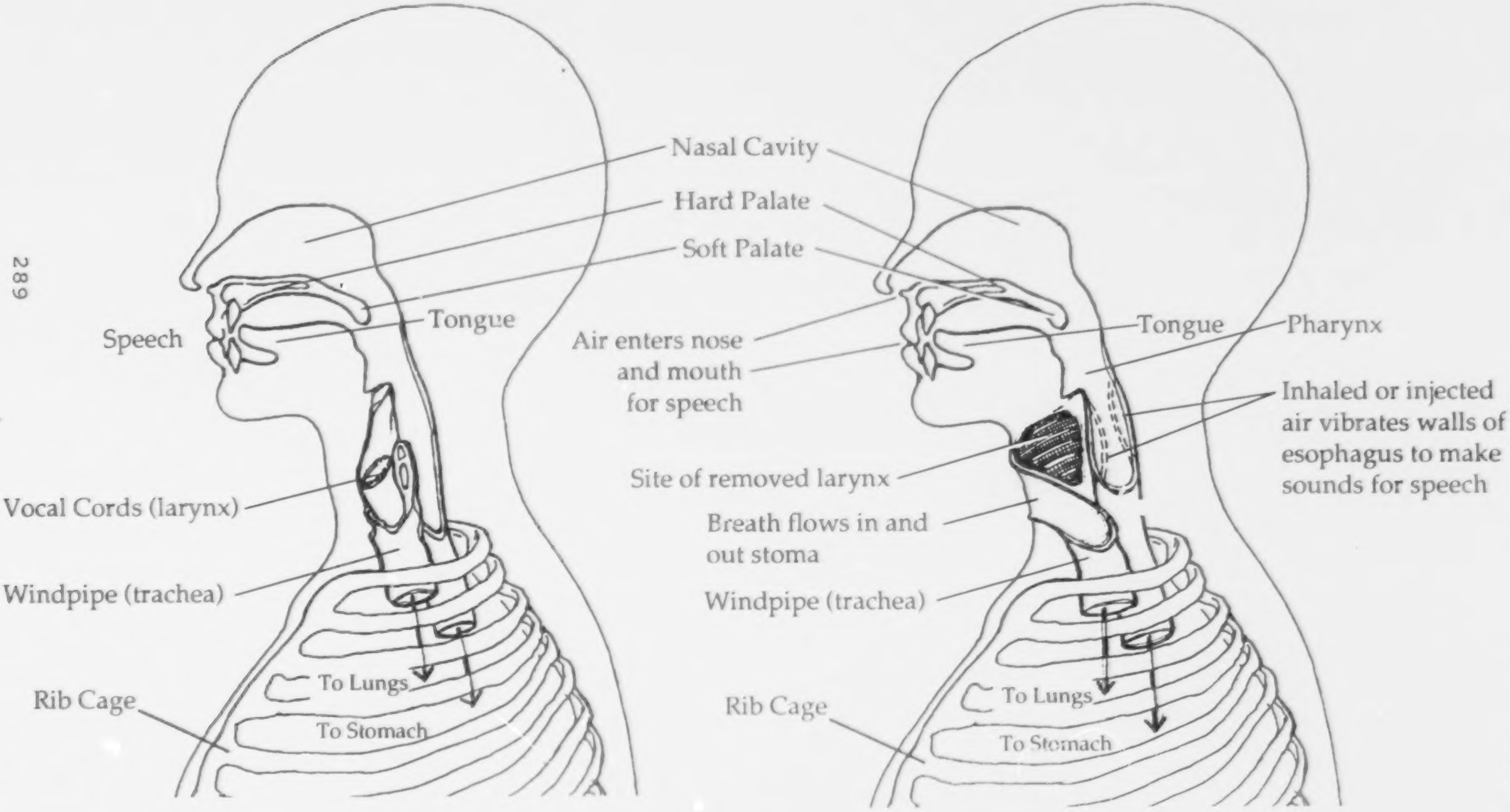
UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. c
2. f
3. e
4. b
5. a
6. d
7. g
8. h
9. Any six of the following:
   CVA; head injury; cerebral palsy; Parkinson's disease; amyotrophic lateral sclerosis (ALS); multiple sclerosis; myasthenia gravis; tongue, jaw, or neck cancer; laryngeal surgery.
10. c
11. d
12. f
13. e
14. a
15. b
16. g
17. The student may list in any order: articulation, phonation, prosody, and resonance
18. a. Vocal cords removed
    b. Opening in the neck (stoma) through which resident breathes

# Anatomical Changes

## Following Laryngectomy



Before Laryngectomy

After Laryngectomy

Nasal Cavity
Hard Palate
Soft Palate
Tongue
Speech
Vocal Cords (larynx)
Windpipe (trachea)
Rib Cage
To Lungs
To Stomach
Air enters nose and mouth for speech
Tongue
Pharynx
Inhaled or injected air vibrates walls of esophagus to make sounds for speech
Site of removed larynx
Breath flows in and out stoma
Windpipe (trachea)
Rib Cage
To Lungs
To Stomach

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletal limitations such as contractures, muscle weakness, and incoordination will also be reviewed.

INFORMATION TOPIC: VI-5 OR DEMONSTRATION:

MUSCULOSKELETAL PROBLEMS WHICH AFFECT MOBILITY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson with their correct definitions.
2. Differentiate between disuse atrophy and pathological atrophy.
3. List three muscular problems which may result in loss of normal ROM.
4. Identify the major cause of loss of muscle or body endurance.
5. List three skeletal factors affecting mobility.
6. List four factors which are evaluated when developing a care plan for a resident.
7. Describe the role of the RNA in relation to the implementation of a care plan for the resident with mobility deficits.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Several care plans, developed by the instructor in which Jane Doe or John Doe has mobility needs

INFORMATIONAL ASSIGNMENT: (None)

Prior to class, review Unit V, Lesson 1 this manual, and review the terms and definitions sections of Unit IV, Functional Anatomy and Physiology, Lessons 1-4.

REFERENCES: (Instructor's Additional Information)

Dorland's Pocket Medical Dictionary. 24th ed. Philadelphia: W.B. Saunders Company, 1989.

INTRODUCTION:

One of the most important things in a resident's life is his/her ability to move. Whether it is moving a body part, like an arm or hand to eat, or more generally moving himself/herself from the bed to the bathroom, mobility is essential to each resident's quality of life and self-esteem. In this lesson we will take a look at some muscular and skeletal related problems that can affect mobility and in turn a resident's ability to perform self-care.

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Contracture - fibrosis of the tendons and ligaments supporting the muscles or joints resulting in permanent loss of normal ROM

   B. Coordination - the synchronized functioning of interrelated organs and body parts (i.e., motor controlling center of brain which enables particular groups of muscles in the legs, trunk, and arms to work together for the performance of walking and other activities)

   C. Endurance - the ability of a muscle (or generally, the body) to withstand stress over long periods of time

   D. Flaccidity - a condition in which muscles display weakness, laxity, softness (i.e., arm is limp and without control following a CVA)

   E. Mobility - the ability of the resident to move a body part or, more generally, his/her whole body through space

   F. Muscle tone - stream of impulses which maintains a partial contraction; keeps muscle in a functional position

   G. Proprioception - the ability of the brain to receive and understand information concerning body movements and the position of the body and its parts; messages come from sensory nerve ends in the muscles and tendons

   H. Spasticity - state of increased muscle tone which causes muscle to be stiff, awkward, and increasingly resistant to stretching

   I. Strength - the ability of a muscle (or generally, the body) to carry a load

II. Muscular Factors Affecting Mobility (II-1)

   A. Loss of muscle or body strength

      1. Loss of muscle tone (atrophy)

a. Disuse atrophy

   1) Caused by muscles not being contracted (i.e., leg or arm muscles not being used after a fall or fracture)

   2) This is generally reversible and muscle tone returns following strengthening exercises and resumption of ADL.

b. Pathological atrophy - a disease or injury causes permanent damage to the nerve supply to the muscle; rehabilitation is impaired (i.e., spinal cord injury - paraplegic, CVA)

2. Loss of functional ROM - also affects the ability of a muscle to be strengthened

   a. Contractures - caused by muscles or joints not receiving full ROM following injury, illness, or disuse (i.e., post-operative below-knee amputee who develops a knee flexion contracture)

   b. Spasticity - generally pathological in nature

      1) Can be caused by cerebral palsy, some CVA's, multiple sclerosis, and Parkinson's (i.e. fixed, unswinging arms during ambulation)

      2) Due to resistance to stretching, can result in flexion contractures

   c. Flaccidity - caused by paralysis resulting in loss of muscle tone and absence of reflexes (i.e., CVA - usually present in affected forearm and hand or lower leg and foot)

   d. Painful ROM (II-2)

      1) Can be caused by injury (i.e., fall)

      2) Can be caused by degenerative joint changes (i.e., osteoarthritis - loss of muscle tone and swollen, painful joints)

      3) Can be caused by inflammation (i.e., bursitis - inflammation of the bursa resulting in tightening of the ligaments and pain during functional ROM)

B. Loss of muscle or body endurance

1. Usually caused by inactivity due to injury, illness, or generalized weakness

2. Usually accompanied by loss of strength, and at times, coordination

C. Loss of coordination

1. Caused by impairment of pathways (nerve) between motor center of the brain and the muscles located in interrelated organs and body parts

2. Can result in subsequent impairment of gross motor skills needed for ADL (i.e., walking - requires coordination of legs, trunk, and arms)

3. Can result in subsequent impairment of fine motor skills needed for ADL (i.e., eating - requires coordination of arms and hands for feeding, jaw for chewing, and throat muscles for swallowing)

D. Loss of proprioception

1. Caused by damage resulting from injury or illness to the sensory pathways in the muscles and tendons and those in the brain which receive and process information concerning movements and position of body parts in space

2. Can result in subsequent impaired balance and performance of ADL

III. Skeletal Factors Affecting Mobility - usually occur in conjunction with, or result in the occurrence of one or more of the muscular and general factors (loss of strength, endurance, coordination, and proprioception)

A. Loss of joint flexibility - due to shortening of ligaments and tendons following trauma (i.e., fall or fracture), illness (i.e., pathological contractures or bursitis)

B. Loss of joint integrity - due to damage or injury to the joint components (i.e., ligaments, cartilage, bone, and capsule)

1. Joint degeneration - damage to the bone and cartilage as in arthritis osteoarthritis and osteoporosis

2. Joint disruption - due to injury (i.e., shoulder

dislocation) or illness (i.e., resident who is diabetic, requiring amputation at the knee joint)

C. Postural changes (II-3)

1. Due to spinal injuries

2. Due to aging (narrowing of spaces between vertebra and decrease in abdominal and trunk muscle tone)

3. Due to disease process

   a. Osteoporosis - compression fractures due to loss of calcium in the bone; may require back brace for stability

   b. Parkinson's - stooped posture with fixed, unswinging arms during ambulation

D. Fractures (Fx's) - usually require casting or immobilization for healing

1. Pathological Fx's - usually occur in residents with cancer and a history of or potential for bone metastasis

2. Depending on the location of the Fx, may require internal fixation with pins, plates, nails, or screws

3. If at the joint, may require joint replacement (i.e., hip, elbow, knee)

IV. Care and Management of Muscular and Skeletal Problems Affecting Mobility

A. Specific care plan for each resident is developed by team; considerations include:

1. Diagnosis

2. Present level of assistance resident requires

3. Resident's restorative potential (determined by evaluations from each member of care team)

4. Weight-bearing status

B. Team members assisting with the development of a specific care plan could include (but not limited to):

1. Physician - determines diagnosis and secondary problems

a. In charge of prescribing medications and overseeing resident status and treatment

b. Prescribes therapy programs, evaluates, and approves subsequent programs or future changes in programs as resident progresses

2. Nursing staff

   a. Assists resident in performance of ADL at maximum level of self-care and mobility.

   b. Communicates any changes in resident's health or mobility to therapists (i.e., resident recovering from influenza has subsequent weakness in legs which could curtail ambulation activities).

   c. Assists resident to and from social activities.

3. Therapists

   a. Speech therapist - may be needed to assist PT and OT consultants and RNA in communicating instructions to an aphasic or apraxic resident (would not be needed in the case of a strictly orthopedic resident who has no speech problem associated with mobility problem)

   b. Occupational therapist

      1) Determines need for and trains in use of assistive devices to maximize mobility of resident in performance of self-care

      2) Designs exercise program necessary to maximize resident's strength for performing fine motor tasks

      3) Might assist resident with transfer activities

   c. Physical therapist

      1) Designs exercise program for impaired muscle groups and those muscle groups which may have to adapt because of impairment (i.e., post-operative hip fracture may have restrictions on weight bearing on affected side and the good leg must take up the slack in order for resident to remain ambulatory).

2) Transfer activities

3) Ambulation activities

4) Determines need for splints, braces, and assistive devices (i.e., CVA with weakness in foot and ankle may require a foot-ankle brace and a quad cane to ambulate, or a resident with a Fx wrist may need a forearm attachment for her walker so that she may remain ambulatory).

d. RNA - after maintenance level is achieved with each resident, the RNA can, under supervision of the therapist(s) and nurse, assist the resident in following his/her program to enhance or maintain mobility

V. Summary and Conclusion

A. Terms and definitions

B. Muscular factors affecting mobility

C. Skeletal factors affecting mobility

D. Care and management of muscular and skeletal problems affecting mobility

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. What are some specific examples you've seen on the job of residents with muscular factors that impair mobility?

2. What conditions might cause the resident to experience painful ROM?

3. How do postural changes impair mobility?

4. How do you perceive your role (as an RNA) in the care and management of muscular and skeletal problems that affect the resident's mobility?

CLASSROOM, LABORATORY, AND OTHER ACTIVITIES:

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the appropriate letter in the blank.

____ 1. The ability of the resident to move a body part, or more generally, his/her whole body through space

____ 2. The synchronized functioning of interrelated organs and body parts

____ 3. The ability of a muscle (or generally, the body) to carry a load

____ 4. The ability of a muscle (or generally, the body) to withstand stress over long periods of time

____ 5. Stream of impulses which maintains a partial contraction; keeps muscle in a functional position

____ 6. The ability of the brain to receive and understand information concerning movements and position of the body and its parts; messages come from sensory nerve ends in the muscles and tendons

____ 7. A condition in which muscles display weakness, laxity, softness

____ 8. Fibrosis of the tendons and ligaments supporting the muscles or joints resulting in permanent loss of normal ROM

a. Flacidity
b. Strength
c. Coordination
d. Proprioception
e. Spasticity
f. Endurance
g. Contracture
h. Muscle tone

9. Briefly state the difference between disuse atrophy and pathological atrophy.

10. List three muscular problems which may result in loss of normal ROM.

a.

b.

c.

11. Identify the major cause of loss of muscle or body endurance.

12. List three skeletal factors which affect mobility.

a.

b.

c.

13. List four factors which are evaluated by the health care team when developing a care plan for a resident.

a.

b.

c.

d.

14. Describe the role of the RNA in relation to the implementation of a care plan for the resident with mobility deficits.

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. i
2. c
3. b
4. f
5. h
6. d
7. a
8. g
9. Disuse atrophy is caused by muscles not being contracted. It is generally reversible and muscle tone returns following strengthening exercises and resumption of ADL. Pathological atrophy is caused by a disease or injury which causes permanent damage to the nerve supply to the muscle and rehabilitation is impaired.
10. The student may list any three of the following:
    a. Contractures
    b. Spasticity
    c. Flaccidity
    d. Painful ROM caused by injury degernative joint changes or inflammation
11. Inactivity
12. The student may list any three of the following:
    a. Loss of joint flexibility
    b. Loss of joint integrity
    c. Postural changes
    d. Fractures
13. a. Diagnosis
    b. Present level of assistance resident requires
    c. Resident's restorative potential
    d. Weight-bearing status
14. After maintenance level is achieved with each resident, the RNA can, under supervision of the therapist(s) assist the resident in following his/her program to enhance or maintain mobility

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

SCOPE OF UNIT:

This unit will introduce specific care problems of the long-term care resident. Included will be memory, cognitive loss, sensory impairment, chronic pain, apraxia, and aphasia. Musculoskeletal limitations such as contractures, muscle weakness, and incoordination will also be reviewed.

INFORMATION TOPIC: VI-6 OR DEMONSTRATION:

## CHRONIC PAIN
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Differentiate between acute and chronic pain.
2. Identify possible causes of chronic pain in the older adult.
3. Identify various ways the older adult may deal with pain.
4. Describe the impact of chronic pain on the rehabilitation potential of a LTC resident.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Lewis, C.B. Aging: The Health Care Challenge. Philadelphia: F.A. Davis Co., 1985.

Maguire, C.H. Care of the Elderly: Health Team Approach. Boston: Little, Brown and Company, 1985.

INTRODUCTION:

Pain is a familiar sensation to everyone. The body suffers damage, such as a cut finger or broken bone. The pain is experienced and expressed. As the body mends, it decreases and finally disappears. In the older adult population, often disease-induced pain is of a chronic nature. It can be and sometimes is a limiting factor in an individual's functional independence.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Bursitis - inflammation of the bursa, a structure found in many joints of the body

   B. Lability - frequent mood swings usually associated with nervous system damage

   C. Osteomyelitis - infection of the bone

   D. Transcutaneous electric nerve stimulation (TENS) - pain control modality involving electrodes placed on the skin which transmit electrical impulses to the nerve endings that block transmission of pain signals to the brain

   E. Ultrasound - physical modality which provides deep heat to body structures

   F. Visual imagery - being able to picture a scene in your mind and focus attention on it

II. Types of Pain

   A. Acute pain - a stimulus attempts to damage tissues of the body for a limited amount of time

      1. Duration is predictable

      2. Intensity is in keeping with the cause

      3. Relieved by removing the stimulus (i.e., infection or broken bone)

   B. Chronic pain - long lasting; affects one physically and emotionally

      1. Duration is unpredictable

      2. Intensity varies with the person

      3. Difficult to relieve (II-1)

III. Causes of Chronic Pain in the Older Adult

- A. Disease-induced pain
  1. Fractures of hips and wrists (II-2)
  2. Arthritis - due to joint destruction
  3. Bursitis - produces deep joint pain
  4. Osteomyelitis
  5. Cancer
- B. Related to previous trauma
  1. Well-mended fractures
  2. Old back injuries
  3. Joint contractures and muscle tightness

IV. Factors Affecting How the Older Adult Deals with Pain

- A. Lifestyle; personality; cultural background; social implications (does not want to be labeled a "complainer")
- B. Nature and extent of pain - many older adults have difficulty localizing the pain
- C. Pain is exhibited in other ways besides verbally
  1. Behaviorally (II-3)
     - a. Lability
     - b. Ashamed of personal limitations
     - c. Depressed/low activity level
     - d. Anxious or frightened
     - e. Angry at the world
     - f. Seek out excessive medical and social attention
  2. Physiological response
     - a. Perspiration, nausea, pallor
     - b. Changes in vital signs

## V. Impact of Chronic Pain on Rehabilitation Potential

- A. Pain response linked closely to emotional status
  - 1. Interactions with others may be limited due to anger, anxiety, or depression.
  - 2. May become more passive, feel out of control
  - 3. Pain response can become all-consuming; transforming the entire personality.
- B. Physical and emotional pain response limits independence in ADL
  - 1. Fatigue
  - 2. Lack of motivation
  - 3. Fear that movement or activity participation will produce pain
  - 4. Inactivity leads to further complications from disuse phenomena. (II-4)
- C. Techniques for relieving chronic pain (II-5)
  - 1. Physical modalities
    - a. Heat and cold
    - b. Ultrasound
    - c. Hydrotherapy
    - d. TENS unit
  - 2. Medication
  - 3. Surgery
  - 4. Behavior/emotional
    - a. Visual imagery
    - b. Relaxation techniques
    - c. Distraction
    - d. Emotional support
  - 5. Functional
    - a. Massage
    - b. Positioning

## VI. Summary and Conclusion

A. Terms and definitions

B. Types of pain

C. Causes of chronic pain in the older adult

D. Factors affecting how the older adult deals with pain

E. Impact of chronic pain on rehabilitation potential

Chronic pain can be a limiting factor or the cause for functional limitations. Any complaints of pain should receive serious attention. The goal of care should be to assist the resident to cope with the pain by reducing the negative emotional response and increasing activity level at a gradual pace.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

INTERACTION ITEMS:

1. From your past work experience, what is an example of chronic pain and pain responses?

2. What are some gestures or body language used to indicate pain or discomfort?

3. Why is there a higher incidence of hip and wrist fractures in the older adult population?

4. What are several complications associated with inactivity?

5. How can involving the resident in meaningful activity be a method of coping with chronic pain?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the letter in the blank.

_____ 1. Frequent mood swings usually associated with nervous system damage

_____ 2. Being able to picture a scene in your mind and focus attention on it

_____ 3. Pain control modality using electrodes placed on the skin which transmit electrical impulses to the nerve endings that block transmission of pain signals to the brain

_____ 4. Inflammation of the bursa, a structure found in many joints of the body

_____ 5. Physical modality which provides deep heat to body structures

_____ 6. Infection of the bone

a. Osteomeylitis

b. Visual imagery

c. Bursitis

d. TENS

e. Lability

f. Ultrasound

7. Chronic pain differs from acute pain in that: (Circle the letter of the best answer.)

   a. The duration is predictable
   b. It is difficult to relieve
   c. It has no emotional effects
   d. It is only found in LTC residents

8. Disease-induced chronic pain may result from: (Circle the letter of the best answer.)

   a. Arthritis and cancer
   b. Joint contractures
   c. An old back injury
   d. A cut on the finger

9. A resident may respond to chronic pain by: (Circle the letter of the best answer.)

   a. Seeking excessive medical and social attention
   b. Displaying frequent mood swings
   c. Becoming overly anxious and frightened
   d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 10. Inactivity due to pain can lead to disuse complications.

____ 11. The emotional response to pain has no effect on the resident's physical well-being.

____ 12. Living in pain on a long-term basis can alter one's personality.

____ 13. Medication and surgery are the only ways to relieve chronic pain.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VI : SPECIFIC CARE PROBLEMS OF THE LTC RESIDENT

ANSWERS TO EVALUATION ITEMS:

1. e
2. b
3. d
4. c
5. f
6. a
7. b
7. a
9. d
10. T
11. F
12. T
13. F

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-1 OR DEMONSTRATION:

## SAFETY MEASURES AND PRECAUTIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify six routine safety measures to be performed prior to a program or activity.
2. Identify the safety devices discussed in this lesson and state two reasons for using them.
3. List three safety considerations to observe prior to transporting a resident in a wheelchair.
4. List six safety measures for the environment.
5. Identify the correct order of the steps taken in each of the following emergency situations:
   a. Hemorrhage
   b. Falls
   c. Seizures

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Safely Handling a Falling Resident
2. HO 2: Sign of Choking
3. Transfer belt (gait belt)
4. Hydraulic lift (if available)
5. Various safety restraints (i.e., vest, posey belt, wrist, etc.)
6. Wheelchair and geri-chair

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant In a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit III, Lessons 14-16; Unit VII, Lessons 48-50. Be prepared to discuss the information concerning safety.

REFERENCES: (Instructor's Additional Information)

Nurse Assistant In a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

INTRODUCTION:

In this lesson we will review and discuss general safety measures which are essential to observe when performing restorative procedures with the residents. Much of this information has already been introduced to you in your training as a nurse assistant, but it is important that you continually review and refresh your knowledge of these safety precautions as well as practice them consistently in order to assure maximum safety for you and your resident.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Routine Safety Measures (II-1)

NOTE: **Prior to proceeding with any program or procedure, the following safety measures which are applicable to the resident with whom you are working should be taken:**

A. Check eyeglasses for cleanliness; make sure the resident wears them, unless they are only necessary for reading.

B. Check hearing aid to make sure it is functioning properly; make sure resident wears it.

C. Handle assistive aids and prosthetics with care; they can be very expensive to replace if damaged (splints, leg prosthesis, ankle/foot support, sling, etc.).

D. Side rails should be up when indicated; check with charge nurse if unsure.

E. When feeding the resident, take precautions to avoid burns from hot food.

F. Give instructions clearly to the resident prior to performing any activity or procedure. Answer any questions he or she asks within the limits of your role; assist resident who needs questions answered by the consultant or supervisor.

G. Allow resident to adjust to changes in position before asking him/her to proceed with the next step of the program.

H. Lock brakes on wheelchair, geri-chair, or bed when resident is not being moved.

I. Correctly apply all safety devices including wheelchair legrests and restraints.

J. Keep scissors handy for emergency situations when you must cut a safety device to move the resident quickly.

K. If you are called away from the resident, even for a moment, properly reapply all safety devices before leaving him/her.

NOTE: If at any time the resident complains of

**dizziness, unsteadiness, pain or discomfort, or becomes combative, stop the program or procedure, and report it to your supervisor.**

II. Safety Devices (II-2)

NOTE: **Restraints will not be included in this discussion, but an informal review would be appropriate based on information from the Nurse Assistant manual.**

A. Transfer belt (gait belt) - should be as snug as possible; will loosen when resident stands

1. Canvas belt with an adjustable buckle; used as a "handle" when transferring or ambulating residents

2. Placed around the resident's waist; the RNA grasps the belt to provide support to the resident as well as a means of controlling or directing the activity.

B. Hydraulic lift

1. A hydraulic lift with a one-piece canvas sling for transferring the extremely heavy or handicapped resident

2. Prior to using the hydraulic lift, always assess whether a severely spastic or handicapped resident can be lifted safely with a lift.

C. Reasons for using these devices

1. To help a resident maintain proper body position and balance throughout program

2. To ensure the resident's safety

3. To ensure the safety of the RNA and prevent injury to the resident

III. Transporting a Resident Safely in a Wheelchair

A. Check wheelchair to ensure that all removable and movable parts including footrests, armrests, and legrests are out of the way when assisting a resident to the wheelchair. (Tilt-back chair should be locked.)

B. After being positioned in the wheelchair, the resident should be instructed or assisted to put his/her arms and hands in his/her lap.

C. Check resident's leg position in legrests and footrests to ensure that the weak leg or foot will not slip during transit and become tangled or twisted.

IV. Safety Measures for the Environment (II-3)

A. Keep all walkways free of hazards.

B. Wipe up any spills on the floor immediately. See that a "Wet Floor" sign is posted while it is drying.

C. Encourage residents to use handrails and grab bars in the bathroom and the hallways.

D. Examine the equipment (i.e., walkers, wheelchairs, assistive devices, etc.) for broken parts on a regular basis. If any are broken or unsafe, report to the charge nurse and your supervisor.

E. Never handle electrical equipment including the telephone, with wet hands or near water.

F. Prior to plugging in any appliance or equipment, inspect cord and plug for fraying or defects and immediately report any equipment that causes electrical shock when handled.

G. Do not use extension cords except as a temporary measure and then for only one appliance and not more than six feet in length.

H. Post emergency phone numbers near each telephone.

I. If leaving a resident unattended following program or procedure, ensure that call light or signal device is within reach of the resident.

V. Safety Procedures in Emergency Situations (II-4)

NOTE: **In any emergency involving a resident, always call for help first.**

A. Hemorrhage - if resident falls and/or cuts himself/herself and is bleeding heavily, follow these steps:

1. Call for help as you go to the resident.

2. If the resident is standing up, assist her/him to lie on a bed, couch, or on the floor so he/she does not faint from blood loss and fall.

3. If the injury is to an arm or leg, and you can move the arm or leg without causing further injury, raise the bleeding site above heart level to slow down the blood coming to the area.

4. Apply firm pressure with your hand over the wound, use a cloth if available.

**NOTE:** **Do not apply a tourniquet.**

5. Stay with resident until more help comes.

6. Follow directions given by a licensed nurse and report as soon as possible to your supervisor.

B. Falls - if resident falls while he/she is unattended:

   1. Call for help immediately.

   2. Do not move resident until a licensed nurse has assessed injuries. Be calm, let the resident know help is on the way. Stay with the resident.

   3. Check for swelling, bruising, position change of any extremities, complaint of pain, and accurately report to charge nurse.

   4. Assist the nurse in charge by checking vital signs.

   5. Assist in moving the resident; as many as four or five people may be required, depending on the size of the resident and location of injury.

   6. If resident falls while attended by the RNA: Do not try to prevent the fall, do try to prevent injury. Use your body in the following steps: (HO 1)

      a. Call for help.

      b. Remember body mechanics - feet apart, back straight, pelvis tilted.

      c. Pull resident close to you - hold on to him/her using the transfer belt or by wrapping your arms around his/her waist.

      d. Gently lower yourself to the floor, and ease resident down, keeping your back straight.

      e. Call for help immediately.

      f. Do not move the resident until examined by a licensed nurse.

C. Seizure - sudden periodic attacks of muscles contracting and relaxing; convulsion

   **NOTE:** **Follow these steps if you think a resident is having a seizure.**

   1. Call for help.

2. Clear the area around the resident of anything hard or sharp.

3. Loosen anything around his/her neck that may make breathing difficult.

4. Put something flat and soft under his/her head.

5. Turn the resident gently on his/her side - this helps to keep the airway clear and the tongue out of the way. Do not try to force his/her mouth open with a hard object or your fingers. A person having a seizure cannot swallow his/her tongue and efforts to prevent him/her from doing so is not only unnecessary, but may cause injury to his/her teeth or jaw.

6. Do not hold the resident down or try to stop his/her movements.

7. Stay with the resident until the seizure has ended.

8. Observe and note the following:

   a. Time seizure started and how long it lasted

   b. If the seizure started at a certain area of the body or was generalized from the start

   c. If the resident was incontinent

D. Choking - elderly residents may be more prone to choking due to weak muscles of the mouth and throat

NOTE: **To determine if a resident is actually choking, observe for the sign of choking. (HO 2) If the resident is choking, take following steps.**

1. Call for help.

2. If the resident is able to cough, speak, or breathe, no special care is needed. Attempts to dislodge the object when the resident does not require assistance might force it farther down into the respiratory tract.

3. The Heimlich maneuver is usually sufficient to "pop" the obstructing object out of the resident's airway.

## VI. Summary and Conclusion

A. Routine safety measures

B. Safety devices

C. Transporting a resident safely in a wheelchair

D. Safety measures for the environment

E. Safety procedures in emergency situations

Some of the information in this lesson plan has been a review for you. In your new and expanded role as resource person and role model for your peers you will find it necessary to continue to use this information to periodically refresh your memory. Through your actions or assistance you can prevent injury not only to yourself and the residents you work with, but others as well. It is also important to remember that it is crucial to immediately report any unsafe conditions to your supervisor. In the following procedures and lessons you will be instructed in more specific care and precautions.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What are some types of safety measures which should be taken prior to proceeding with any program or procedure?
2. What are two safety devices, other than restraints?
3. What are some of the measures you can take in your working environment to help prevent accidents?
4. What is the first thing you should do when dealing with any emergency?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Review the procedure for the proper application of a transfer (gait) belt. Refer to the Nurse Assistant Manual, Lesson 50.
2. Review the procedure for the proper use of a hydraulic lift. Refer to the Nurse Assistant Manual, Lesson 49.
3. Have students demonstrate how to safely transport a resident in a wheelchair, making sure they check the precautions noted in this lesson.
4. Simulate different emergency situations and demonstrate with students appropriate measures (including falls, seizures, hemorrhages, and choking). Include removal of restraints in an emergency.

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

1. Identify six routine safety measures to be performed prior to a program or activity.

   a.

   b.

   c.

   d.

   e.

   f.

2. Identify the two safety devices discussed in this lesson.

   a.

   b.

3. State two reasons for using the safety devices you listed for question 2.

   a.

   b.

4. List three safety considerations to observe prior to transporting a resident in a wheelchair.

   a.

   b.

   c.

5. List six safety measures for the environment.

   a.

   b.

   c.

   d.

(Question 5 continued)

e.

f.

Indicate the correct steps to take when dealing with each of the following emergency situations:

HEMORRHAGE

___ 6. Raise the limb that is bleeding above heart level if possible.

___ 7. Stay with resident until more help comes.

___ 8. Call for help as you go to the resident.

___ 9. Help resident sit or lie down.

___ 10. Apply firm pressure over the wound.

___ 11. Follow directions of licensed nurse and report Stat to supervisor.

a. Step 1

b. Step 2

c. Step 3

d. Step 4

e. Step 5

f. Step 6

FALLS

___ 12. Check for swelling, bruising, position change of any extremities, complaint of pain, and report to charge nurse.

___ 13. Assist in moving resident.

___ 14. Call for help.

___ 15. Stay with resident and calm him/her while waiting for licensed nurse to come and assess injuries.

___ 16. Assist nurse in charge by checking vital signs.

a. Step 1

b. Step 2

c. Step 3

d. Step 4

e. Step 5

SEIZURES

___ 17. Stay with resident until the seizure has ended.

___ 18. Turn resident gently on his/her side.

___ 19. Clear area around resident of anything hard or sharp.

___ 20. Loosen anything around resident's neck.

___ 21. Do not hold resident down or try to stop his/her movements.

___ 22. Put something flat and soft under resident's head.

___ 23. Call for help.

___ 24. Observe and note appropriate data to report to supervisor.

a. Step 1

b. Step 2

c. Step 3

d. Step 4

e. Step 5

f. Step 6

g. Step 7

h. Step 8

LESSON PLAN: 1

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1. The student may list any six of the following:
   a. Check eyeglasses for cleanliness; make sure the resident wears them, unless they are only necessary for reading.
   b. Check hearing aid to make sure it is functioning properly; make sure resident wears it.
   c. Handle assistive aids and prosthetics with care; they can be very expensive to replace if damaged (splints, leg prosthesis, ankle/foot support, sling, etc.).
   d. Side rails should be up when indicated; check with charge nurse if unsure.
   e. When feeding the resident, take precautions to avoid burns from hot food.
   f. Give instructions clearly to the resident prior to performing any activity or procedure. Answer any questions he or she asks within the limits of your role; assist resident who needs questions answered by the consultant or supervisor.
   g. Allow resident to adjust to changes in position before asking him/her to proceed with the next step of the program.
   h. Lock brakes on wheelchair, geri-chair, or bed when resident is not being moved.
   i. Correctly apply all safety devices including wheelchair legrests and restraints.
   j. Keep scissors handy for emergency situations when you must cut a safety device to move the resident quickly.
   k. If you are called away from the resident, even for a moment, properly reapply all safety devices before leaving him/her.
2. a. Transfer (gait) belt
   b. Hydraulic lift
3. The student may list any two of the following:
   a. To help a resident maintain proper body position and balance
   b. To ensure the resident's safety
   c. To ensure the safety of the RNA and prevent injury to the resident
4. The student may list any three of the following:
   a. Check wheelchair to ensure that all removable and movable parts including footrests, armrests, and legrests are out of the way when assisting a resident to the wheelchair. (Tilt-back chair should be locked.)
   b. After being positioned in the wheelchair, the resident should be instructed or assisted to put his/her arms and hands in his/her lap.
   c. Check resident's leg position in legrests and footrests to ensure that the weak leg or foot will not slip

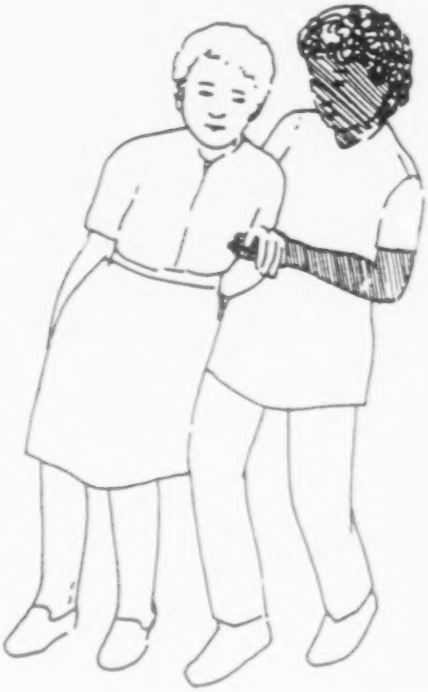
during transit and become tangled or twisted.

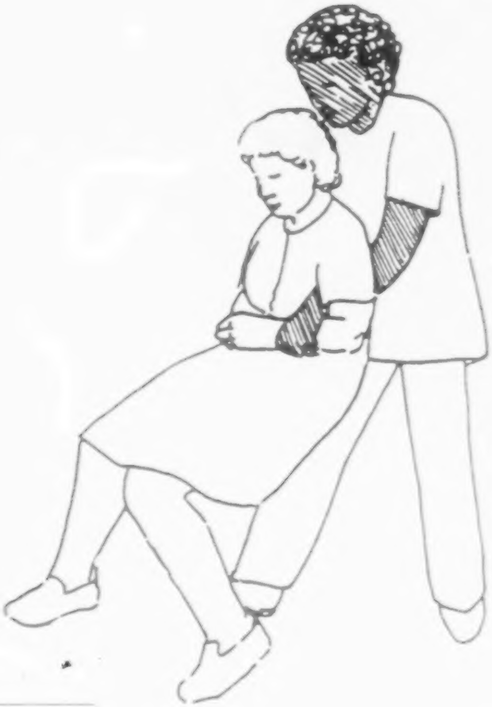
5. The student may list any six of the following:
    a. Keep all walkways free of hazards.
    b. Wipe up any spills on the floor immediately. See that a "Wet Floor" sign is posted while it is drying.
    c. Encourage residents to use handrails and grab bars in the bathroom and the hallways.
    d. Examine the equipment (i.e., walkers, wheelchairs, assistive devices, etc.) for broken parts on a regular basis. If any are broken or unsafe, report to the charge nurse and your supervisor.
    e. Never handle electrical equipment including the telephone, with wet hands or near water
    f. Prior to plugging in any appliance or equipment, inspect cord and plug for fraying or defects and immediately report any equipment that causes electrical shock when handled.
    g. Do not use extension cords except as a temporary measure and then for only one appliance and not more than six feet in length.
    h. Post emergency phone numbers near each telephone.
    i. If leaving a resident unattended following program or procedure, ensure that call light or signal device is within reach of the resident.

6. c
7. e
8. a
9. b
10. d
11. f
12. c
13. e
14. a
15. b
16. d
17. g
18. e
19. b
20. c
21. f
22. d
23. a
24. h

# Safely Handling
## a Falling Resident

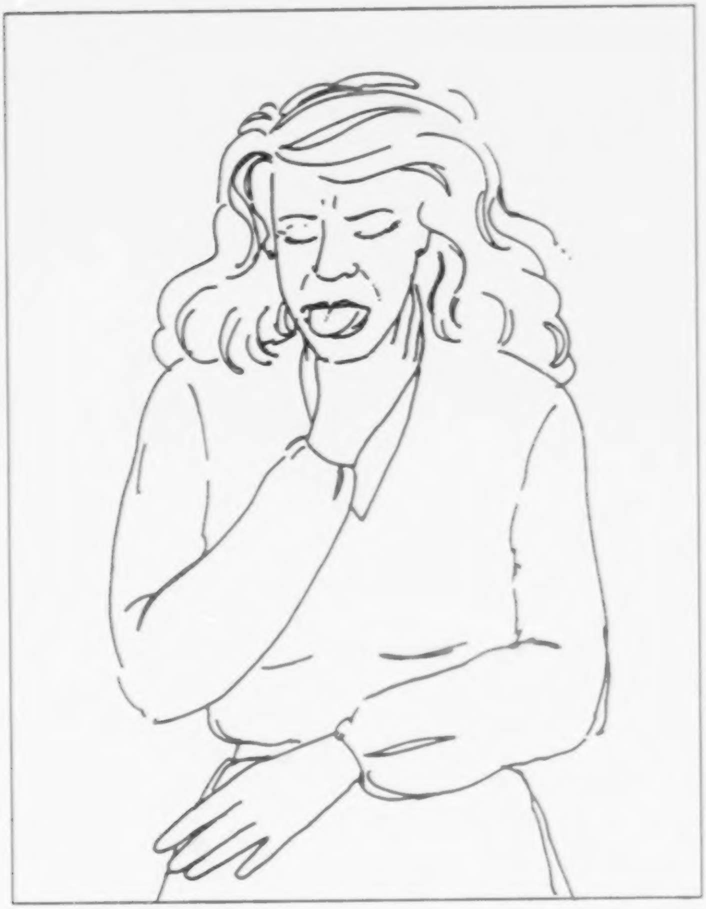
When handling a falling resident, pull him/her close to your body and gently ease her/him to the floor.





HO 2

# Sign of Choking



LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-2 OR DEMONSTRATION:

OBSERVATION AND REPORTING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify key points regarding the importance of observation skills.
2. List three methods used to develop good observation skills.
3. Identify two key points in effective reporting and oral communication with health care workers.
4. Observe and report significant data, given a simulated case.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Activity: Observation Skills

INFORMATIONAL ASSIGNMENT: (Student)

Review Unit II, Lesson 1, "Interpersonal Communication"

REFERENCES: (Instructor's Additional Information)

Chaffee-Sabonis, B. About Occupational Therapy. Lanhan, MD: Moosy Publishing, in manuscript form.

Hopkins, H. Ed. Occupational Therapy. 7th ed. Philadelphia: J.B. Lippincott Company, 1988.

INTRODUCTION:

Providing useful observations to nurses and therapists assists them in giving proper care to the LTC resident. As a RNA you must refine your skills in both observation and reporting to insure carry over of rehabilitation procedure from day to day. This lesson will focus on key principles of observation and methods to improve reporting and oral communications.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Importance of Observation Skills

   A. Keen observation is valuable whenever there is interaction with a resident.

   B. Gathering information by simply being present and noticing

   C. Requires consideration of all aspects of the person

      1. Obvious and measurable behaviors

      2. Intangible feelings

      3. Mind, body, and spirit

   D. Provides therapy consultant with information regarding routine behavior; changes in program may occur based on such reporting.

   E. Constant observation and subsequent reporting of findings can alert therapists to need for evaluation and treatment of new residents. (II-1)

II. Developing Good Observation Skills

   A. Build on existing abilities.

   B. Observe with a goal in mind (i.e., what are you looking for?).

   C. Gather information systematically; progress from general (i.e., wearing a blue shirt) to detailed (pointed collar with tiny white buttons).

   D. Focus attention while observing.

   E. Practice making observations to refine skills; with focus and attention to details, the observer begins to pick up more subtle information. (II-1)

III. Key Points in Effective Reporting and Oral Communication

A. Report information regarding resident treatment using consistent format or structure to organize data.

B. Separate information into two categories: objective and subjective.

1. Objective data - information which is measured, quantified, or observed
   Example: "I got up at 5:30 a.m. today."

2. Subjective data - information which cannot be overtly measured or verified; personal interpretation is given
   Example: "I got up early today."

3. Subjective information should be supported by objective facts (i.e., "Mrs. Jones was in a bad mood today."),and should not be documented without an objective statement such as "as evidenced by her cursing and demanding a new nurse." (II-3)

C. Use multiple channels (both written and verbal) to exchange information with therapy consultants and other nursing staff.

D. Practice in delivering information concisely and clearly develops skill.

E. Until proficiency is developed in sorting out pertinent information to report, seek assistance from nurses and therapists.

**NOTE: Written documentation and procedures for maintaining records will vary from setting to setting. Ask your supervisor.** (II-4)

IV. Significant Data to Report

A. Significant data to the RNA and the rehabilitation staff may be different than that of a CNA.

B. Things to observe

1. ADL performance and level of independence

2. Quality of movement during an exercise or activity

3. How a procedure was initiated and carried out by the resident

4. Indications of resident's attitudes and feelings regarding the treatment program

5. Resident's comfort level when working independently in new tasks (II-5)

C. The therapy consultant and nurse work closely with the RNA to insure observational guidelines are established.

D. Remember, observation skills and reporting are not new abilities for you. With additional background information about the resident's therapy program, pertinent observations will become more obvious.

V. Summary and Conclusion

A. Importance of observation skills

B. Developing good observation skills

C. Key points in effective reporting and oral communication involves key principles

D. Significant data to report

This lesson has reviewed the importance of observation skills and good reporting in the care of the LTC resident. You have been provided with some strategies to develop these abilities to their fullest. Combined with the assistance from nursing staff and therapists, you are on your way to becoming a skilled and valuable reporter.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. How might one "observe" depression? loneliness? or frustration?

2. How does one observe with focus?

3. Give an example of a subjective statement supported by objective facts.

4. How would you employ multiple channels to relay information about change in a resident's ability to complete his/her articulation drills?

5. What is an objective statement about the quality of movement of a person with Parkinson's disease?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Provide pictures of residents interacting with members of the rehabilitation staff and ask students to make three observations about the residents' physical characteristics.

2. Observation exercise - (See Handout 1) The intention of this exercise is to seek out physical descriptions of people with the object of making the description so complete the person can be "seen" by the reader. The focus is on the person, not the clothing.

3. A group exercise which demonstrates the power of observation when attention is focused and directed is "lemon find" (of course apples, limes, etc. could be used) From a bag of randomly selected lemons, equal in amount to number of participants, each person takes one. Everyone then studies his/her lemon carefully for a few minutes, examining every detail of it. Then the lemons are returned to the pile and the participants see if they can identify "their" lemon.

   People are usually surprised how items, which otherwise seem identical, are distinguished by seemingly insignificant details. It is our attention to details--our observation skill--which makes the difference.

LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

1. Which of the following statements is true about the importance of observation skills? (Circle the letter of the best answer.)

    a. Observations of a treatment session will have no effect on the treatment planning process.
    b. It is okay to hold daily observations and report them all at once, one time each month.
    c. The mind, body, and spirit should be considered during observation of residents.
    d. Anyone can accurately observe information pertinent to a restorative program.

2. In order to develop good observation skills: (Circle the letter of the TWO best answers.)

    a. Gather information haphazardly.
    b. Know what you are looking for.
    c. Practice observing in everyday situations.
    d. Read information about it.

3. List two key points in effective reporting with other health care workers.

    a.

    b.

4. Given the following situation, write an objective statement regarding level of independence.

    Mrs. Jones pushed herself into the bathroom, proceeded to position her wheelchair next to the toilet, removed the legrest and the arm of the chair. She lifted herself off the seat, preparing to swing her buttocks onto the stool, neglecting to pull down her slacks. Halfway through the transfer, she realized the raised toilet seat was missing. She "froze" and proceeded to yell loudly for the nurse.

5. Look at the drawings provided (Figure 1 and Figure 2) and list three observations for each. Focus on body positioning and physical characteristics.

Figure 1

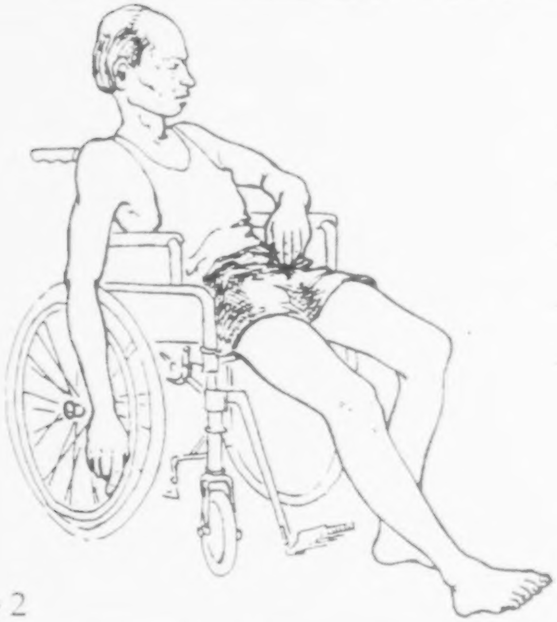
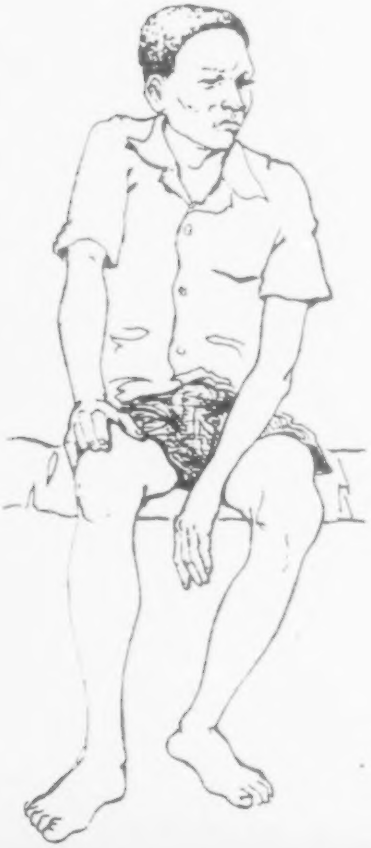


Figure 2



LESSON PLAN: 2

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1. c
2. b and c
3. The student may list any two of the following:
   a. Report information regarding resident treatment using consistent format or structure to organize data.
   b. Separate information into objective and subjective.
   c. Use multiple channels of communication.
   d. Practice until proficient.
   e. Seek assistance from other staff to develop skills.
4. Mrs. Jones requires moderate assistance in toilet transfers.
5. Figure 1: The student may list any three of the following: Balding; right arm dangling from chair; sliding out of chair; wearing shorts; middle aged man; looking toward left side; etc.

   Figure 2: The student may list any three of the following: Supporting weight on the right side; left arm dangling; wearing shorts; looking toward the left; looks serious, possibly listening to someone(?); relatively young man

HO 1

# Observation Skills

**Physical Characteristics**
Describe a person noting those special qualities that make him or her a unique individual. Start with gender, age, and race. Notice face, hair, body build, posture, arms, legs, hands, fingernails. Note any scars/defects and identifying marks.

**Movements**
Distinguish quality and frequency (i.e., slow, fast, fidgety, rigid, sedentary, pawing, etc.).

**Communications**
Note manner of speaking, quality of voice, content of speech, non-verbal messages, etc.

**Attitude**
Observe tone and manner, mood, response to others, qualities, or characteristics.

**How he/she makes you feel**
Be aware of your own emotion (i.e., relaxed, nervous, happy, frustrated, annoyed, want/don't want further contact).

**Other**

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive re-training, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-3 AND DEMONSTRATION: VII-3

## GENERAL PRINCIPLES OF DRAPING THE RESIDENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define draping.
2. List three reasons for draping a resident.
3. Identify the types of residents needing to be draped.
4. Identify rules for draping.
5. Demonstrate specific draping techniques:
    a. Upper extremity or shoulder - sitting position
    b. Upper extremity or shoulder - lying position
    c. Lower extremity
    d. Back

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Draping
2. TM 2: Reasons for Draping
3. HO 1: Rules for Draping
4. HO 2: Draping for Upper Extremity or Shoulder Procedure
5. HO 3: Draping for Lower Extremity Procedure or Exercise
6. HO 4: Draping for Back Procedure
7. Various surfaces including mat, bed, or treatment table

8. Sheets
9. Pillows and pillow covers
10. Towels

INFORMATIONAL ASSIGNMENT:

Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, 1987. Read Unit V, Lesson 1, Heating and Cooling Equipment.

REFERENCES: (Instructor's Additional Information)

Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, 1987.

INTRODUCTION:

It will sometimes be your responsibility to assist a resident in preparing to perform his/her exercise program either in his/her room or in the rehabilitation department. An important aspect of this is protection of the resident's right to privacy. In this lesson, we will discuss the reasons for draping a resident as well as those types of residents most in need of draping. There are rules for draping that will help you to drape the resident efficiently while providing access to the area of the body to be exposed for treatment with the minimum amount of embarrassment to the resident.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions (TM 1)

   A. Draping - to cover the resident so that only the area to be worked with is exposed and maximum privacy and warmth is maintained (II-1)

   B. Modality - refers to special equipment which provides therapeutic sensations for treatment of residents (i.e., heat, pressure, cold, electrical stimulation, etc.)

II. Reasons for Draping (TM 2)

   A. Protects the privacy of the resident (II-2)

   B. Prevents embarassment of the resident and others

   C. Exposes a specific area of the body for:

      1. Performance of exercises

      2. Treatment or procedure to be performed by therapist or assistant

   D. Keeps the resident warm

III. Residents in Need of Draping (II-3)

   A. Residents receiving restorative exercise (i.e., on a mat, in an open area, or in a semi-private room)

   B. When assisting a therapist, assistant, or licensed nurse in specific procedures:

      1. Massage

      2. Residents using special equipment (modalities) -

         a. Ultrasound

         b. Moist heat packs (Hydrocollator packs)

         c. Ice packs

         d. Electrical stimulation

         e. TENS unit

IV. Rules for Draping (HO 1)

A. Respect the resident's modesty. Each resident should be treated in private if possible.

B. The amount and method of draping depends on:

1. Position of the resident

2. Warmth of the room or therapy department

3. Area of the body to be worked with

4. Amount of clothing which must be removed

C. Provide the resident with a drape sheet or cotton bath blanket and request resident to cover himself/herself.

D. Expose only the area to be worked with. Other residents, staff, or visitors may inadvertently look into the resident's room or therapy department.

E. The resident should not have to hold the draping around himself/herself.

F. The draping should be secure, but not tight.

G. Use material such as terry cloth or Turkish toweling to cover genital and breast areas. These areas should never be exposed unless it is absolutely necessary.

H. Keep the resident warm.

## V. Steps of Procedures For Draping Residents

A. Draping for upper extremity or shoulder - sitting position (HO 2)

1. If the resident is in a hospital gown, have him/her remove his/her arm from the sleeve on the side to be treated.

2. Tie the gown under the armpit so the shoulder and arm are exposed.

B. Draping for upper extremity or shoulder - lying supine (HO 2)

1. Have the resident lie supine.

2. Cover the resident with a sheet.

3. Lift the arm to be treated to the outside of the sheet and pull sheet up into armpit.

C. Draping the lower extremity: (HO 3)

1. Have the resident lie supine.

2. Cover the resident with the sheet.

3. Pull the sheet to the midline between legs.

4. Lift the leg to be treated.

5. Place the lower corner of the sheet under the leg to be treated.

6. Wrap the corner of the sheet around the leg and place on resident's waist.

**NOTE: This exposes the lower extremity but keeps the resident's genital area covered.**

D. Draping for back: (HO 4)

1. Have the resident lie prone.

2. Place pillow under resident's abdomen for comfort.

3. Place a rolled towel under front of ankles for comfort.

4. Cover the resident with a sheet.

5. Pull the sheet down to expose as much of the resident's back as necessary.

6. If upper back is not to be treated a towel may be placed over upper back.

7. If upper back is to be treated and the resident is female, place rolled towels at the side of breasts.

VI. Summary and Conclusions:

A. Terms and definitions

B. Reasons for draping

C. Residents in need of draping

D. Rules for draping

E. Steps of procedures for draping residents

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What does modality mean?
2. What might be the most important reason for draping a resident?
3. What residents might need your assistance in draping?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates draping procedures and students return the demonstration.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

1. Define draping according to the definition given in class. (Circle the letter of the correct answer.)

    a. Refers to special equipment which provide therapeutic sensations
    b. To cover the resident so that only the area to be worked with is exposed and maximum privacy and warmth are maintained

2. List three reasons for draping a resident.

    a.

    b.

    c.

Put an "X" on the blank next to the description of those residents that would need to be draped.

___ 3. A resident in street clothes who is ambulating with a walker.

___ 4. A resident who needs a warm moist pack to the low back.

___ 5. A resident who is to receive ultrasound by the licensed therapist or assistant to the right shoulder.

___ 6. A resident on a mat in the gym area who is to receive leg exercise.

For each of the following, write "T" if the statement is true or "F" if it is false.

___ 7. When draping a resident, you should expose only the area to be treated.

___ 8. The resident should hold the draping to keep it in position.

___ 9. The draping should be wrapped very tightly to hold in warmth.

___ 10. Terry cloth or Turkish toweling should be used to cover genital and breast areas.

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS: NAME OF STUDENT: ____________________

## SPECIFIC DRAPING TECHNIQUES

Equipment:
1. Treatment Table
2. Sheets
3. Towels
4. Pillows and pillow covers

| DID THE STUDENT | YES | NO |
|---|---|---|
| Drape for Upper Extremity or Shoulder Treatment: Sitting Position<br>1. If the resident is wearing a hospital gown, have him/her remove his/her arm from the sleeve on the side to be treated. | | |
| 2. Tie the gown under the armpit so the shoulder and arm are exposed. | | |
| Drape for Upper Extremity or Shoulder Treatment: Supine Position<br>1. Have the resident lie supine. | | |
| 2. Cover the resident with a sheet. | | |
| 3. Lift the arm to be treated to the outside of the sheet and pull sheet up into armpit. | | |
| Drape for Lower Extremity Treatment or Exercise<br>1. Have the resident lie supine. | | |
| 2. Cover the resident with the sheet. | | |
| 3. Pull the sheet to the midline between legs. | | |
| 4. Lift the leg to be treated. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 5. Place the lower corner of the sheet under the leg to be treated. | | |
| 6. Wrap the corner of the sheet around the leg and place on the resident's waist. | | |
| Drape for Back Treatment<br>1. Have the resident lie prone.<br>2. Place pillow under abdomen for comfort.<br>3. Place a rolled towel under front of ankles for comfort.<br>4. Cover the resident with a sheet.<br>5. Pull the sheet down to expose as much of the resident's back as needed. | | |
| 6. If upper back is not to be treated a towel may be placed over upper back. | | |
| 7. If upper back is to be treated and the resident is female, place rolled towels at side of the breasts. | | |

The student has satisfactorily completed the procedure "SPECIFIC DRAPING TECHNIQUES" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 3

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

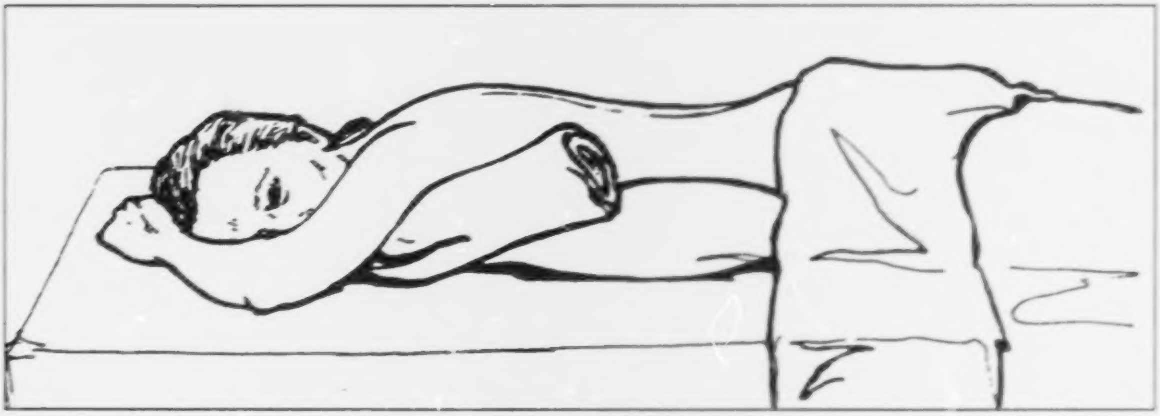
ANSWERS TO EVALUATION ITEMS:

1. b

2. The student may list any three of the following:
   a. Protects the modesty of the resident
   b. Prevents embarassment of the resident and others
   c. Exposes a specific area of the body for:
      1. Performance of exercises
      2. Treatment or procedure to be performed by therapist or assistant
   d. Keeps the resident warm
3.
4. X
5. X
6. X
7. T
8. F
9. F
10. T

# Draping

Cover the resident so that adequate treatment may be provided with the least possible exposure.



# Reasons for Draping

1. Protects modesty
2. Prevents embarrassment
3. Exposes a specific area of the body
4. Keeps resident warm

# Rules for Draping

HO 1

1. Respect the resident's modesty. Each resident should be treated in private.

2. The amount of draping depends on:
   - a. Position of the resident
   - b. Warmth of the treatment room
   - c. Area being treated
   - d. Amount of clothing which must be removed

3. Provide the resident with a drape sheet or cotton bath blanket and request that the resident cover himself/herself.

4. Expose only the area to be treated. Other residents, staff, or visitors may inadvertently look into the resident's room or therapy department.

5. The resident should not have to hold the draping around him/her.

6. The draping should be secure but not tight.

7. Use material such as terry cloth or Turkish toweling to cover genital and breast areas. These areas should never be exposed unless it is absolutely necessary.

8. Keep the resident warm.

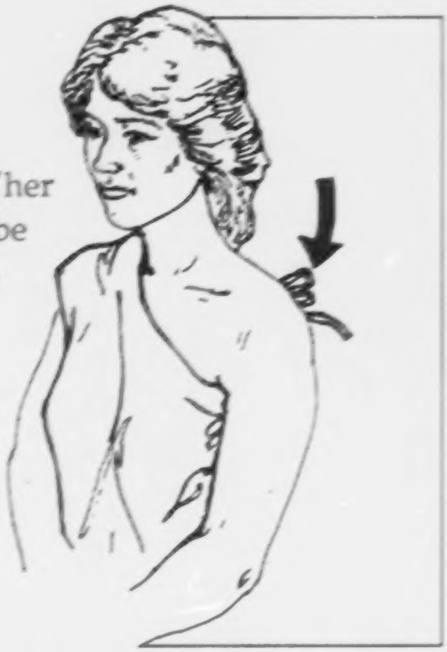
HO 2

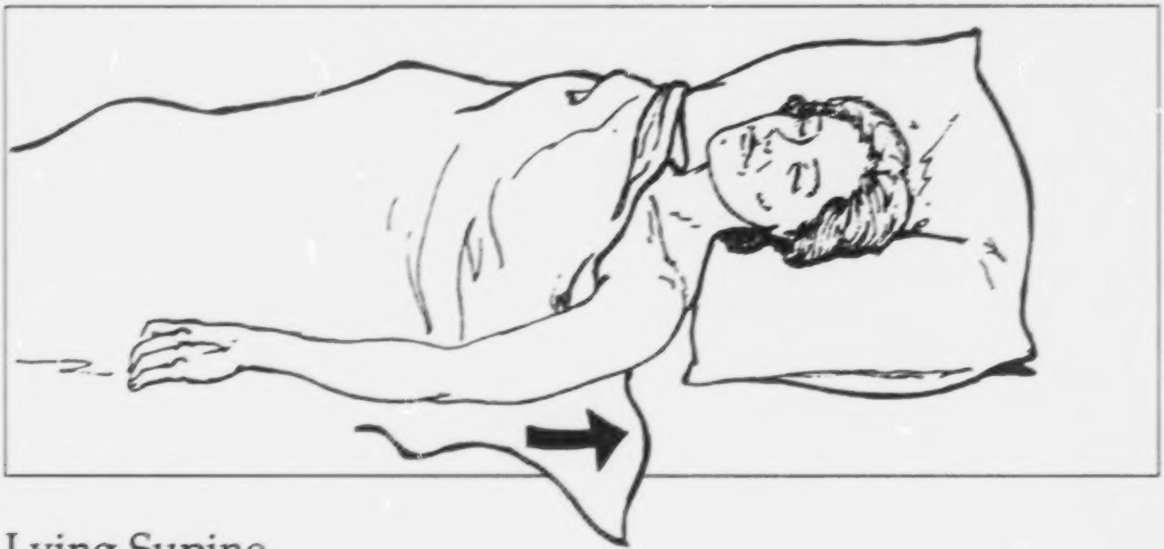
# Draping

## for Upper Extremity or Shoulder Procedure

### Sitting Position

If the resident is in a hospital gown, have him/her remove the arm from the sleeve on the side to be treated. Then tie the gown under the armpit so the shoulder and arm are exposed.



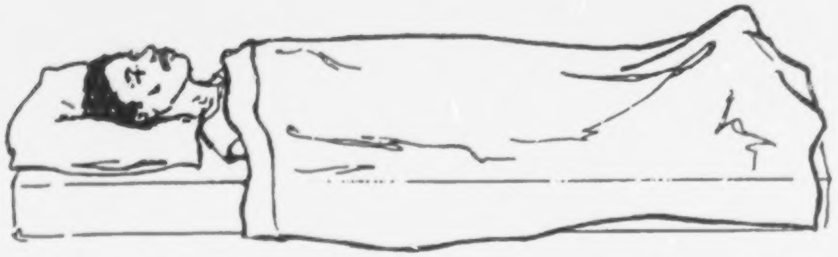


### Lying Supine

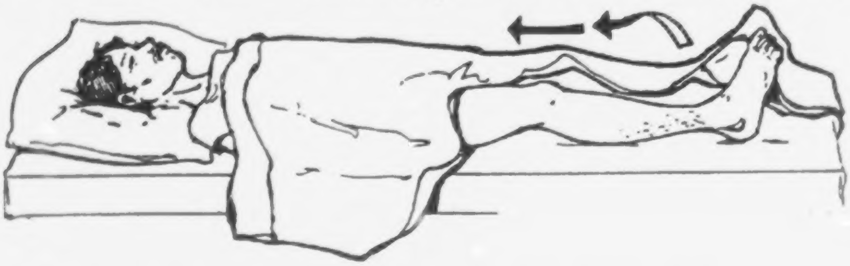
Have the resident lie down. Cover with a sheet. Lift the arm to be treated and pull the sheet up into the armpit.

# Draping

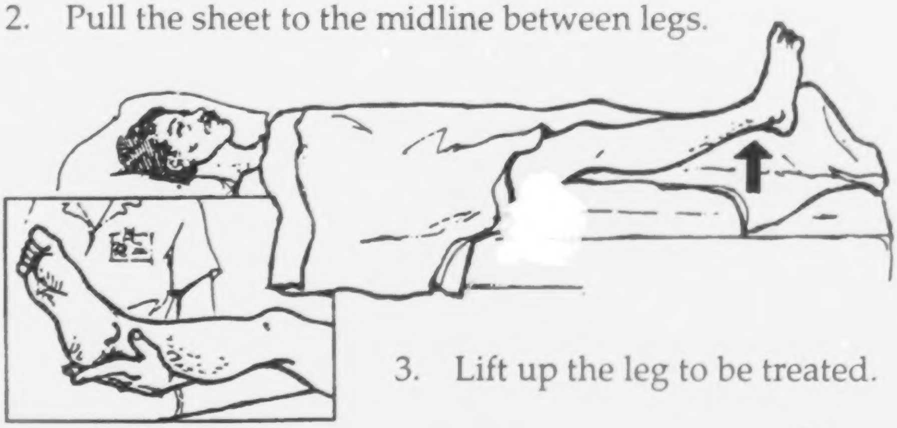
## Lower Extremity Procedure or Exercise



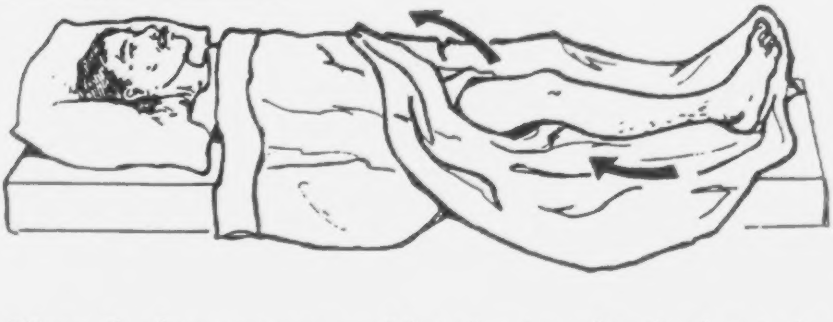
1. Have the resident lie supine. Cover resident with a sheet.



2. Pull the sheet to the midline between legs.



3. Lift up the leg to be treated.

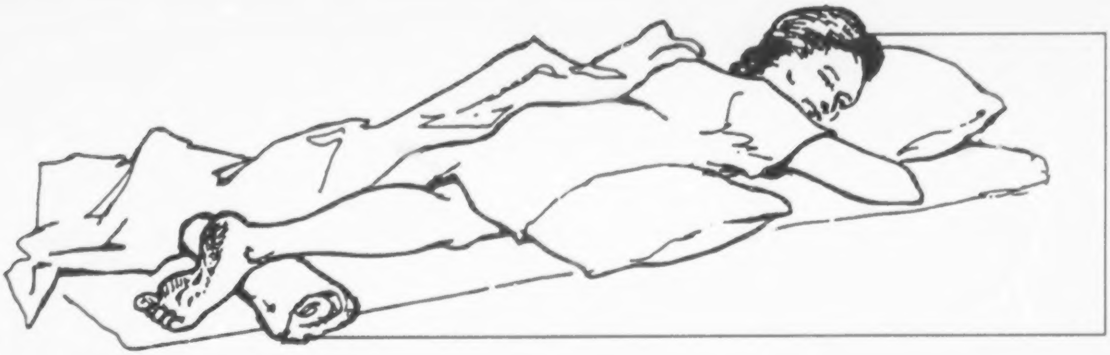


4. Wrap the lower corner of the sheet under the leg to be treated. Wrap the corner of the sheet around the leg and place it on resident's waist.

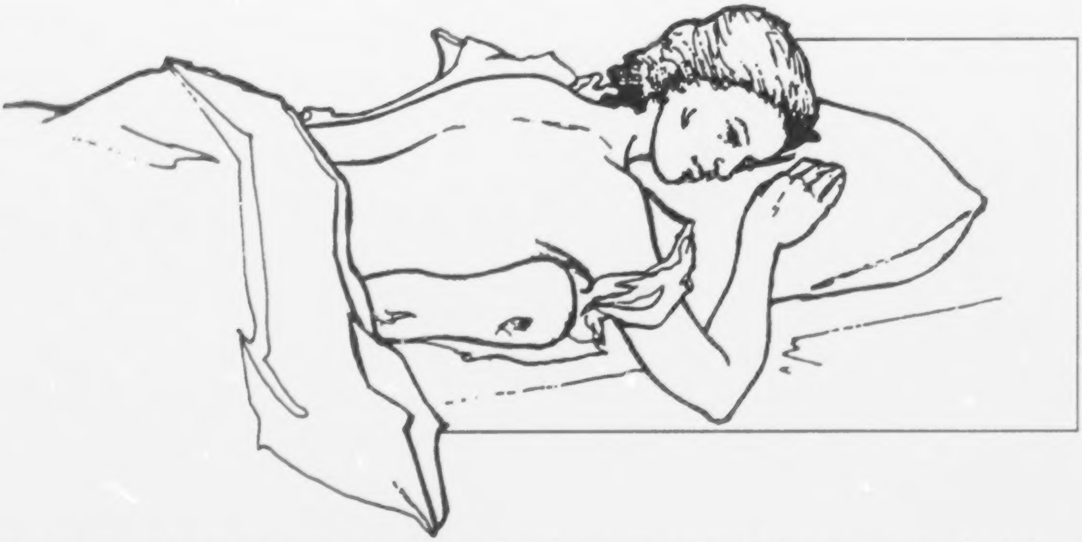
HO 4

# Draping

## for Back Procedure



Have the resident lie prone. Place a pillow under the resident's abdomen for comfort. Also place a rolled towel under the front of the ankles for comfort. Cover the resident with a sheet.



Pull the sheet down to expose as much of the resident's back as needed for treatment. If the upper back is not to be treated, a towel may be placed over the upper back. If the upper back is to be treated also, and if the resident is female, place rolled towels at the side of the breasts.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-4 OR DEMONSTRATION:

ASSISTIVE DEVICES AND ENVIRONMENTAL ADAPTATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Explain how assistive devices can maximize a resident's level of independence.
2. Identify examples of environmental adaptation in a long-term care facility.
3. Identify assistive devices used in grooming and hygiene, dressing, and self-feeding tasks.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Self-Help Aids for Grooming and Hygiene
2. HO 2: Self-Help Aids for Dressing
3. HO 3: Self-Help Aids for Feeding
4. Slide Set: Environmental Adaptation in a Long-Term Care Facility; Available from the American Occupational Therapy Association; for ordering information, call toll-free 1(800) THE-AOTA

## INFORMATIONAL ASSIGNMENT: (Student)

## REFERENCES: (Instructor's Additional Information)

La Jolla Veterans Administration Medical Center - (slide presentation)

Lewis, S.C. The Mature Years. Slack Incorporated, 1979.

Kiernat, J.M. "Environment: The Hidden Modality." Physical and Occupational Therapy in Geratrics 2:3-12, 1982.

Ryan, S.E. The Certified Occupational Therapy Assistant. Roles and Responsibilities. Slack Incorporated, 1986.

## INTRODUCTION:

As one ages, there is a continuous loss of the ability to adapt the body's changes, whether the changes are due to a disease or the normal process of aging. Often the ability to care for one's daily needs and maintain a productive life style are lost. A primary goal, as a restorative nurse assistant, should be to assist the resident in maintaining maximum independence in activities of daily living. In fact, a study of nursing home residents has shown that the more independent a person is in activities of daily living, the better his/her chances are for survival and early discharge. By working with your therapy consultants, you will learn new ways of making performance of daily tasks easier. This lesson will introduce the concept of adaptation and highlight common assistive devices used in your facility.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE PROCEDURES

OUTLINE: (Key Points)

I. Value of Assistive Devices and Environmental Modifications in Maximizing Self-Care Independence

- A. Allows task to be completed more quickly or with less energy
- B. Permits safety in task completion; may require less supervision when using a device (II-1)
- C. May be used as a temporary measure to insure a successful experience; can take away the device once strength or movement has improved
- D. Fosters group acceptance (i.e., more acceptable personal appearance or more socially appropriate way of completing an activity such as self-feeding)
- E. Improves resident's feelings of self-worth; motivates changes in activity level

II. Environmental Adaptation

- A. Environment shapes the actions of persons of all ages but is an even greater influence on the elderly and others whose abilities are reduced by illness. (II-2)
- B. Environmental modification or simple adjustments can maximize performance in ADL and therapy program by compensating for sensory, cognitive, or physical losses.
  - 1. Modification of physical space
    - a. Labeling doors with large letters or pictures to decrease confusion
    - b. Use of hand-held shower when bathing to compensate for poor balance
    - c. Large-faced clocks and oversized calendars to improve orientation to time
    - d. Reduce visual clutter and stimuli to increase perceptual awareness
    - e. Eliminate architectural barriers in high traffic areas, bathrooms, dining room, etc.

f. Riser blocks under legs of bed or favorite chair to ease transfer

g. Mirrors in resident's rooms at proper height to facilitate self-care skills and reinforce self-identity

2. Modification of time

a. Dressing training at appropriate time of day (II-3)

b. Therapy sessions scheduled when resident's energy level is highest

c. Balance of work, self-care, and leisure activities

C. Environmental modification is a mutual process; resident should be involved in adapting situations or equipment to his/her particular needs

1. Promotes individuality; self-esteem

2. Can provide continuity with past experiences

III. Assistive Devices

NOTE: Assistive devices are prescribed by the occupational therapy consultant after observation and evaluation of the resident

A. Grooming and hygiene (HO 1)

1. Raised toilet seat

2. Grab bars

3. Fingernail suction brush

4. Built-up toothbrush or comb/brush

5. Suction denture brush

6. Universal cuff

7. Long-handled sponge (II-4)

8. Wash mitt

B. Dressing (HO 2)

1. Long-handled shoehorn

2. Sock aid

    3. Dressing stick
    4. Reachers
    5. Button aid
    6. Adapted shoe closures

C. Feeding (HO 3)

    1. Rocker knife
    2. Dycem™
    3. Plate guard
    4. Weighted utensils
    5. Long straws
    6. Swivel utensils
    7. Built-up utensils
    8. Overhead sling
    9. Lapboard
    10. Universal cuff

IV. Summary and Conclusion

A. Value of assistive devices and environmental modifications in maximizing self-care independence

B. Environmental adaptation

C. Assistive devices

This lesson has shown how assistive devices and environmental adaptation can help you help the resident regain independence in ADL. Now you are ready to learn more about specific self-care compensatory techniques.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

INTERACTION ITEMS:

1. What is an example of an assistive device that would make toileting or bathing safer for a resident experiencing problems with balance? (raised toilet seat, grab bars, tub bench, soap-on-rope, hand-held shower)

2. Thinking about your own home, how does the environment shape your actions and feelings?

3. Why is it so important to schedule self-care training sessions in the morning?

4. What physical loss may require the use of a universal cuff?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students break into pairs and role-play a resident/RNA interaction. Introduce use of a piece of adaptive equipment to the resident. Try to simulate the physical loss appropriate for your device.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

EVALUATION ITEMS:

1. Assistive devices: (Circle the letter of the best answer.)

   a. Should be selected by the resident.
   b. Are usually expensive.
   c. Should save time and energy.
   d. Are never used on a long-term basis.

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 2. Devices can improve a resident's self-worth by permitting success in ADL.

____ 3. Residents will always need supervision when using assistive devices.

____ 4. A resident may be more willing to eat a meal with others if an assistive device will make eating easier or less messy.

____ 5. It usually takes more energy and time to use assistive devices.

6. One example of an environmental adaptation of physical space is: (Circle the letter of the best answer.)

   a. Scheduling treatment sessions in the early afternoon.
   b. Encouraging residents to wear street clothes.
   c. Calling residents by their formal name.
   d. Riser blocks under legs of bed to ease transfer.

7. Use of a hand-held shower will: (Circle the letter of the best answer.)

   a. Make the job easier for the RNA.
   b. Help the resident compensate for poor sitting balance.
   c. Make the bath process take longer.
   d. Insure the resident is clean.

For each of the following, match the most appropriate piece of equipment with the resident's condition by writing the letter in the blank.

____ 8. Recent hip replacement

____ 9. Inability to grasp, due to arthritis

____ 10. One-handedness, post-stroke

____ 11. Limited shoulder and arm motion due to multiple sclerosis

____ 12. No hand motion due to spinal cord injury

a. Rocker knife

b. Sock aid

c. Reachers

d. Built-up handles on utensils

e. Universal cuff

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 13. Built-up handles make objects easier and more comfortable to grasp.

____ 14. Schedule resident treatment sessions to be most convenient for you.

____ 15. Dycem™ provides a non-slip surface to help stabilize objects.

____ 16. Labeling dresser drawers may help the resident to select his/her own clothing.

____ 17. Use of a raised toilet seat following knee surgery would be an example of temporary use of an assistive device.

LESSON PLAN: 4

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

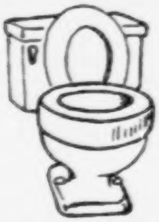
ANSWERS TO EVALUATION ITEMS:

1. c
2. T
3. F
4. T
5. T
6. d
7. b
8. b
9. d
10. a
11. c
12. e
13. T
14. F
15. T
16. T
17. T

HO 1

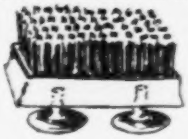
# Self-Help Aids

## For Grooming and Hygiene



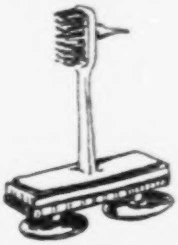
Raised Toilet Seat

Permits ease in getting off toilet when legs are weak. Limits hip flexion. Eases transfer from a wheel chair.



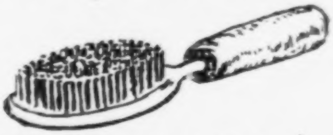
Suction-Cup Fingernail Brush

Assists the resident with loss of use of one hand to maintain cleanliness.



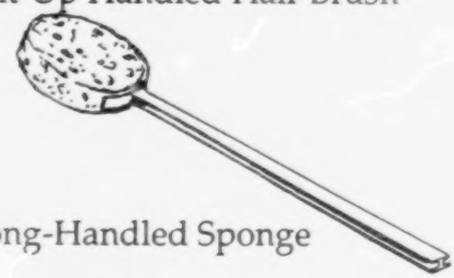
Suction-Cup Denture Brush

Allows one-handed cleaning of dentures. Suctions into sink.



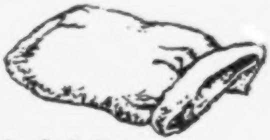
Built-Up Handled Hair Brush

Makes holding brush easier and more comfortable.



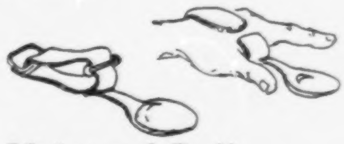
Long-Handled Sponge

Substitutes for limited strength and range.



Wash Mitt

Used when hand grasp is too limited to hold a washcloth.



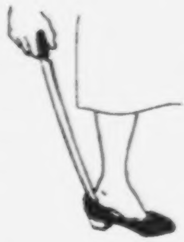
Universal Cuff

Substitutes for hand grasp. Can be adapted to hold a toothbrush, razor, comb/brush, etc.

HO 2

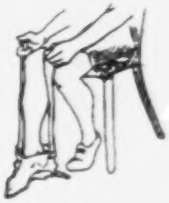
# Self-Help Aids

## for Dressing



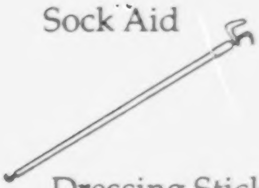
Long-Handled Shoehorn

Substitutes for lack of range in arms and trunk. Used if resident is unable to bend over safely.



Sock Aid

Used when hip range is limited or arm/hand strength is poor.

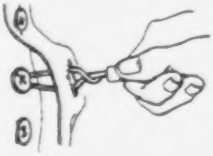


Dressing Stick

Compensates for limited reach or muscle weakness. Used to pull clothing over feet or to reach hangers in the closet.

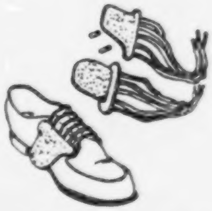
Reachers

Compensates for limited reach or muscle weakness. Used to start clothing over body parts, remove clothes from shelves, pick up objects from floor.



Button Aid

Used when fingers are unable to manipulate the button to fasten it.



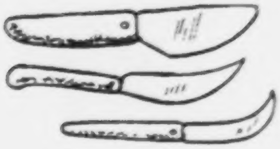
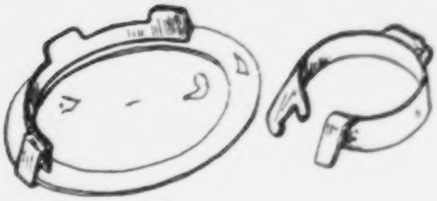
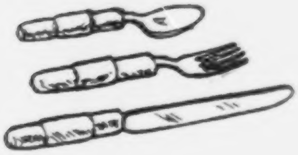
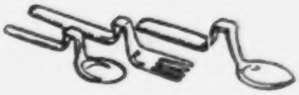
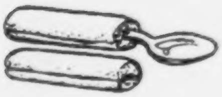
Nylon Tape Fastener (Velcro™) Shoe Closure

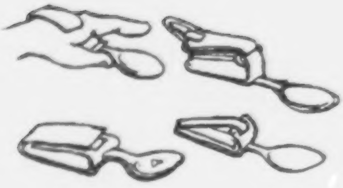
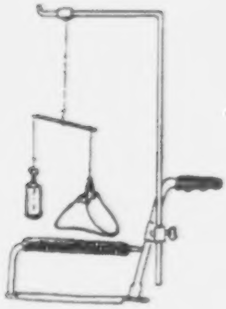
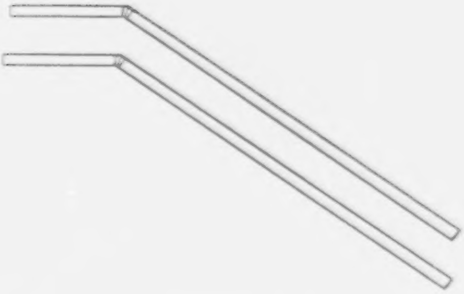
One of the many adaptations is unable to tie shoes due to loss of use of one hand, poor trunk control, or limitations in hip range.

HO 3

# Self-Help Aids

## for Feeding

| Device | Purpose |
|---|---|
|  | **Rocker Knife**<br>Cutting food one-handed. Use rocking motion from center of plate towards outside of plate |
|  | **Plate Guard**<br>Prevents food from moving around plate. Aids in food placement on utensils. |
|  | **Weighted Utensils**<br>May decrease tremorous movement while eating. |
|  | **Swivel Utensils**<br>Substitutes for lack of rotation of forearm. Allows one to put food on utensil without turning wrist over. |
|  | **Built-up Handles**<br>Allows for a functional grasp when muscles are weak or joints are contracted. |

| Device | Purpose |
|---|---|
|  | **Universal Cuff**<br>Substitutes for poor or absent grip of the hand. Utensils can be interchanged by resident. |
|  | **Overhead Sling**<br>Allows weak arm muscles to power the arm for functional tasks. |
| **Other Aids** | |
| Dycem™ | **Dycem™**<br>Blue, rubbery material - a small square shaped piece provides a non-slip surface - Stabilizes objects for one-hand use. |
|  | **Long Straws**<br>Substitutes for limited range of neck, poor trunk balance, or use of arms/hands. |

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-5 OR DEMONSTRATION:

## POSITIONING TECHNIQUES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify key points in the rationale for good positioning techniques.
2. Identify aspects of the role of the RNA in positioning the resident.
3. Identify positioning techniques for the resident who is sitting.
4. Identify the correct bed positioning for the resident in the supine position.
5. State the purposes of splinting.
6. Identify types of splints and state the purpose of each.
7. Match positioning devices commonly used in a long-term care facility to their purpose.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Age-Related Postural Changes
2. HO 2: Positioning Techniques: Sitting
3. HO 3: Bed Positioning for the Hemiplegic Resident
4. HO 4: Commonly Used Splints
5. HO 5: Positioning Devices
6. HO 6: Activity: Positioning Techniques

INFORMATIONAL ASSIGNMENT: (Student)

*Nurse Assistant in a Long-Term Care Facility*. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987. Review Unit I, Lesson Plan 46, "Lifting and Moving the Resident."

REFERENCES: (Instructor's Additional Information)

Lewis, C.B. *Aging: The Health Care Challenge*. Philadelphia: F.A. Davis Company, 1985.

Hill, J.P. *Spinal Cord Injury: A Guide to Functional Outcomes in Occupational Therapy*. Rockville, MD: Aspen Press, 1986.

*Nurse Assistant in a Long-Term Care Facility*. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

*Mosby's Medical and Nursing Dictionary*. 2nd ed. St. Louis: The C.V. Mosby Company, 1986.

INTRODUCTION:

Positioning is a key factor in helping the resident with motor or sensory losses to receive information from his/her surroundings. You will work closely with nursing staff and therapy consultants to assist the resident in achieving functional posture. For each resident with whom you work, additional options for adaptation and compensation will be discovered.

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE PROCEDURES

OUTLINE: (Key Points)

I. Rationale for Proper Positioning (II-1)

   A. Prevent deformity - symmetrical base of support and proper skeletal alignment (HO 1)

      1. Kyphosis - misalignment of the vertebral column in which the upper spine curves convexly and protrudes when viewing resident from the side

      2. Lordosis - misalignment of the vertebral column in which the lower spine is concaved and curves inwardly when viewed from the side

   B. Prevent decubitus ulcers (pressure sores) - combination of positioning, proper seat cushion, and weight shifts

   C. Promote function - trunk/pelvis stability frees the hands for wheelchair propulsion and functional activities

   D. Upgrade sitting tolerance - proper positioning leads to support and comfort which leads to ability to sit for longer periods of time

   E. Enhance respiratory function - increases vital capacity by decreasing compression on the diaphragm

II. Responsibilities of the RNA in Positioning the Resident

   A. Assist the therapy consultant in securing the prescribed positioning devices.

   B. Learn the technique from the consultant and demonstrate ability to carry out the procedure.

   C. Relay information, as per the consultant, to other staff members.

      1. Schedule of position changes

      2. Rationale for positioning techniques

      3. Technique

   D. Reinforce consistent use of proper techniques.

        1. Illustrations posted above resident's bed

        2. Diagram and written directions in nurses' Kardex™ (II-2)

    E. Serve as a liaison for staff and therapy consultant.

III. Sitting Posture

    A. Be aware of proper posture. (HO 2)

        1. Head erect and in midline, neck in extension

        2. Trunk supported symmetrically in extension

        3. Arms forward, scapulae protracted, shoulder height equal; hands within resident's field of vision (II-3)

        4. Hips and knees flexed to 90 degrees

        5. Feet supported by wheelchair footplates or flat on the floor

        6. Lapboard or pillow may be necessary to support a nonfunctional arm, to prevent subluxation.

    B. Do not allow a resident to sit upright without assuming this position. Could lead to increased muscle tone, overstretching of weak muscles, contractures of joints, discomfort, and anxiety for the resident.

IV. Bed Positioning (HO 3)

    A. The choice of bed positioning is determined on an individual basis.

    B. The position should be opposite the pattern of greatest amount of muscle tone.

    C. All residents should be positioned in side-lying position on left and right sides; lying on stomach and back.

    D. Be aware of correct positioning.

        1. Side-lying

            a. Leg resting on bed remains straight; pillow is placed between legs.

            b. Trunk in good skeletal alignment

        c. Weakest extremity is supported by a pillow, shoulder is forward with arm straight.

    2. Supine

        a. Head and back in good skeletal alignment

        b. Pillow placed under affected hip and shoulder

V. Splinting

A. Splinting is used to:

- 1. Prevent deformity
- 2. Correct existing deformity
- 3. Protect a body part (II-4)

B. Prescribed and fabricated by the therapist

C. Can be easily removed and replaced; a wearing schedule must be followed

D. When possible, the resident learns how to manage the splint

E. All problems with wear/care should be directed to the charge nurse and therapist

- 1. Skin redness lasting 20 minutes after splint removal
- 2. Numbness; severe pain; swelling

F. Types and purpose of each (HO 4)

- 1. Resting hand splint - supports entire hand to maintain correct position
- 2. Wrist cock-up splint - supports wrist but frees fingers and thumb for activity
- 3. Hand cone - fits in palm to prevent curling of fingers into a fist
- 4. Ankle-foot splint - maintains 90 degree angle of ankle to prevent deformity
- 5. Elbow splint - used to correct flexion contracture of the elbow

VI. Positioning Devices

A. Can be homemade or purchased, upon the consultant's recommendations (HO 5)

B. Wheelchair sitting

1. Lapboard

2. Seat cushion

3. Head support

4. Lateral supports

5. Abductor pads

C. Arm supports - to prevent subluxation, a painful shoulder, and/or decrease swelling in the hand

1. Suspension sling (moveable)

2. Lapboard

3. Arm trough

4. Hemisling (static)

VII. Summary and Conclusion

A. Rationale for proper positioning

B. Responsibilities of the RNA in positioning the resident

C. Sitting posture

D. Bed positioning

E. Splinting

F. Positioning devices

This lesson has provided basic knowledge about positioning the resident with a neurological and/or degenerative condition. The next lesson will focus on specific self-care retraining techniques.

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

INTERACTION ITEMS:

1. What is a disabling condition that limits a resident's ability to maintain good posture?
2. In your experience, what is the most effective way to relay information to other staff members?
3. Why might it be important for the resident's hands to be positioned within his/her visual field?
4. What is a disabling condition that might require a splint?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide students into pairs and use Handout 6: Activity: Positioning Techniques to reinforce the information presented in this lesson.

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE PROCEDURES

EVALUATION ITEMS:

1. Which of the following statements are true about positioning techniques? (Circle the letters of the **TWO** best answers.)

   a. Contractures of the joints are often caused by infrequent or poor positioning techniques.
   b. Sitting tolerance will improve when proper positioning techniques are employed.
   c. Positioning techniques have little or no effect on the resident's ability to complete ADL.
   d. Proper positioning alone will prevent pressure sores.

2. All of the following describe a good sitting posture EXCEPT: (Circle the letter of the best answer.)

   a. Hips and knees flexed to 90 degrees
   b. Trunk is symmetrical
   c. Head is turned towards the weaker side
   d. Nonfunctional arm supported by a pillow or lapboard

For each of the following, mark "T" if the statement is true, or "F" if it is false.

____ 3. The choice of bed position depends on how long the resident has been disabled.

____ 4. The weakest arm is supported by a pillow in a side-lying position.

____ 5. An extremity exhibiting abnormal tone should be positioned opposite to its typical or usual posture.

6. When positioning the resident to lie on his/her back, a pillow is placed: (Circle the letter of the best answer.)

   a. Under the affected knee
   b. Under the resident's head
   c. At the bottom of the bed
   d. Under affected hip and shoulder

7. One method utilized to make sure all staff are well-informed of a resident's positioning technique is: (Circle the letter of the best answer.)

   a. Assume it is the therapist's responsibility
   b. Send a memo to the administrator.
   c. Post an illustration in the resident's room.
   d. Tell the CNAs when you see them in the breakroom.

8. List three purposes of splinting.

   a.

   b.

   c.

9. The resting hand splint: (Circle the letter of the best answer.)

   a. Supports the wrist but frees the fingers and thumb
   b. Is the same as a hand cone
   c. Supports the wrist, palm, fingers, and thumb
   d. Straightens the elbow

10. The ankle-foot splint prevents deformity by maintaining an angle of: (Circle the letter of the best answer.)

   a. 30°
   b. 60°
   c. 90°
   d. 180°

Match the positioning device with the appropriate purpose by writing the letter in the blank.

____ 11. Keeps the resident from falling sideways in the wheelchair

____ 12. May prevent a painful shoulder

____ 13. Helps to reduce pressure

____ 14. Keeps the legs from rotating outward when sitting

____ 15. Positions the head in midline

a. Abductor pad

b. Lateral supports

c. Arm Trough

d. Head support

e. Seat cushion

LESSON PLAN: 5

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

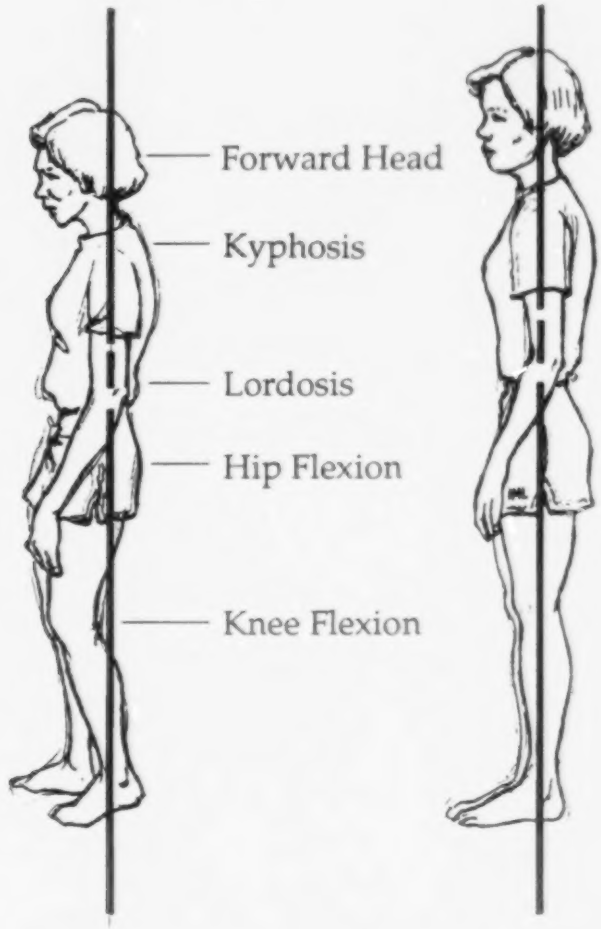
UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. a and b
2. c
3. F
4. T
5. T
6. d
7. c
8. a. Prevent deformity
   b. Correct existing deformity
   c. Protect body part
9. c
10. c
11. b
12. c
13. e
14. a
15. d

HO 1

# Age-Related Postural Changes

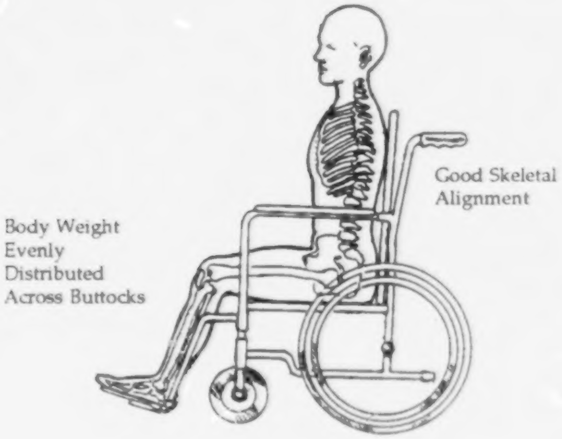

Forward Head
Kyphosis
Lordosis
Hip Flexion
Knee Flexion

**Reasons for Changes**

1. Decline in strength and flexibility
2. Changing structure of invertebral disk
3. Neurological disease
4. Arthritic involvement
5. Cardiopulmonary decrement
6. Low activity level

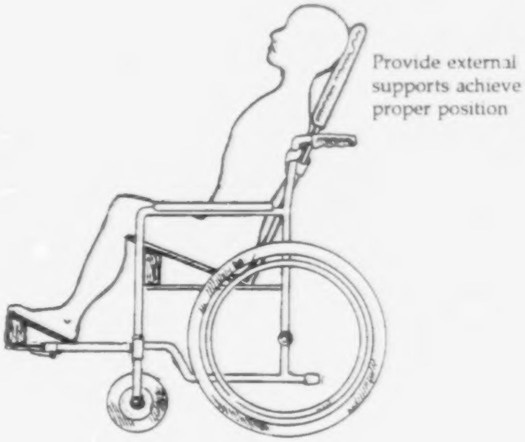
# Positioning Techniques:

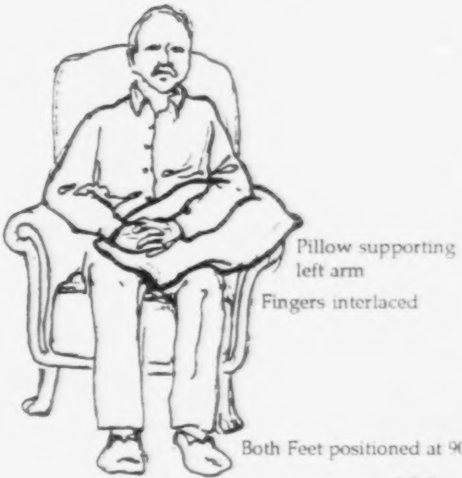
## Sitting


Good Skeletal Alignment
Body Weight Evenly Distributed Across Buttocks

**Points to Remember**

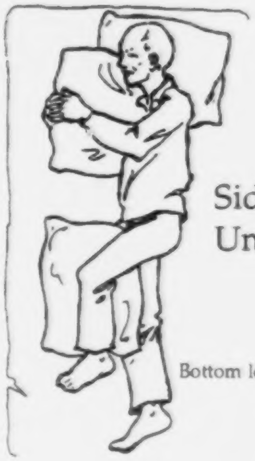
- Position away from spastic patterns
- Encourage symmetrical posture
- Do not force extremely uncomfortable positions
- Be sensitive to resident's appearance and gadget tolerance


Provide external supports achieve proper position

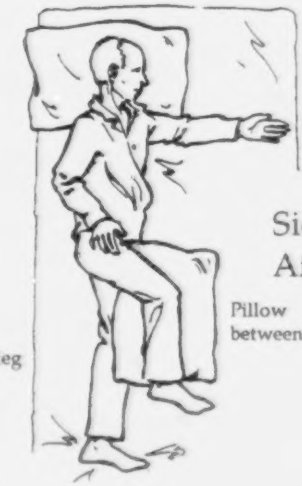

Pillow supporting left arm
Fingers interlaced
Both Feet positioned at 90°

- Adaptations for the ambulatory resident

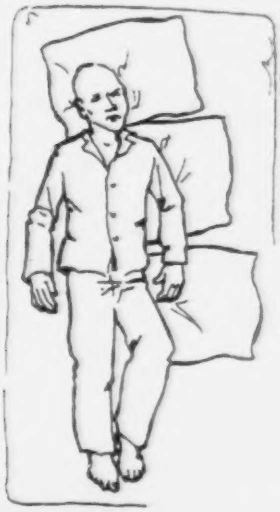
# Bed Positioning for the Hemiplegic Resident


Pillow between arms
Interlaced fingers
Pillow between legs
Bottom leg straight

Side-Lying on Unaffected Side


Rotate palm toward ceiling
Pillow between legs
Bottom leg straight

Side-Lying on Affected Side


Pillow beneath left scapula
Pillow under left hip

Lying on Back-Position Weaker Side of Body

### Points to Remember

- Position away from spastic patterns
- Encourage symmetrical postures
- Do not use footboards
- Promote weight-bearing on affected side
- Reposition as necessary

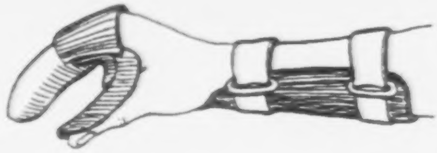
HO 4

# Commonly Used Splints

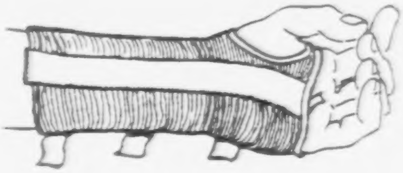
## Splints Can Protect, Maintain, or Correct

Splint

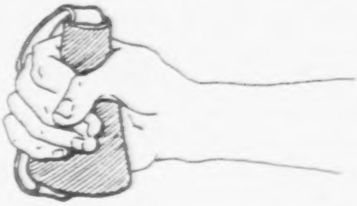
Benefit



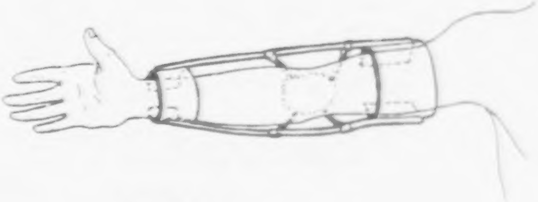
**Resting Hand Splint**
Protects paralyzed hand. Maintains good wrist, finger/thumb position. Used in arthritis, post-CVA, head injury.



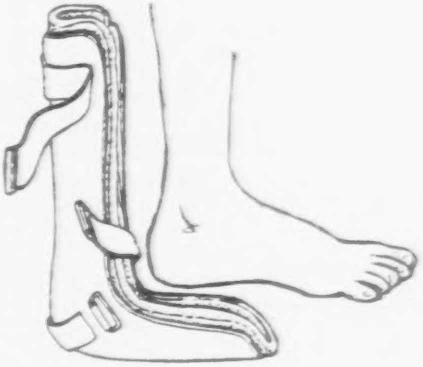
**Wrist Cock-up Splint**
Positions wrist in extension for maximal hand function. Used in spinal cord injury and arthritis. Relieves painful wrist.



**Hand Cone**
Holds tightly flexed hand in slight extension. Maintains an open hand for better hygiene. Beneficial to those with arthritis or muscle imbalance.

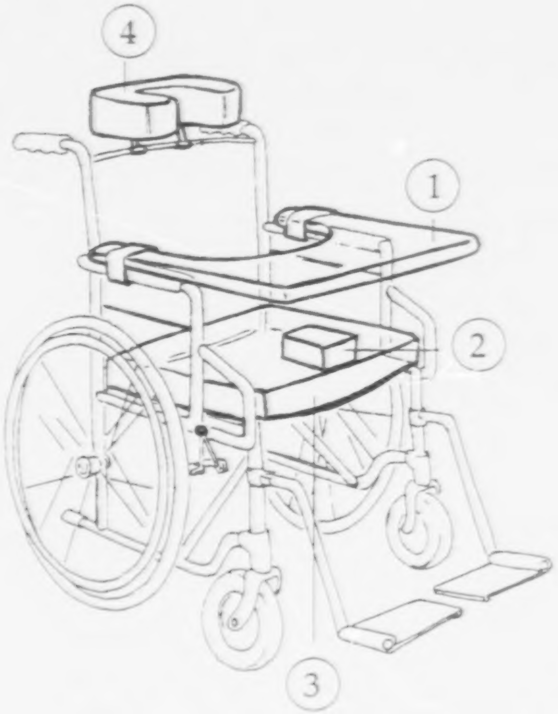


**Elbow Splint**
Corrects joint contractures due to muscle weakness, imbalance, or poor positioning.

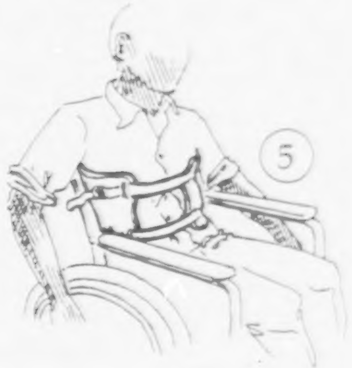


**Ankle-Foot Splint**
Provides correct ankle position to prevent footdrop. Used by long-term non-ambulatory residents.

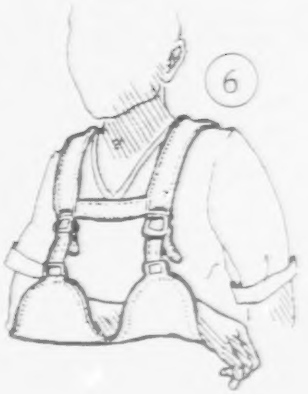
# Positioning Devices



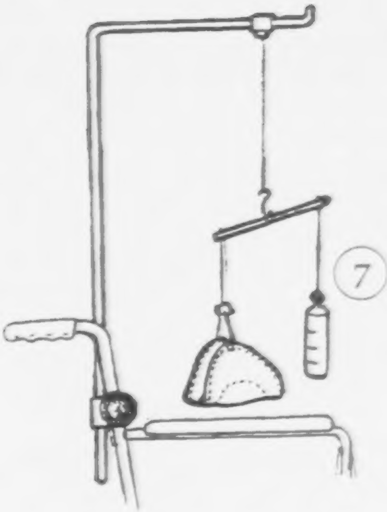
1. Lapboard - a useful surface assists arm positioning and trunk control.
2. Abductor pad - keeps hip from outwardly rotating.
3. Seat cushion - helps prevent decubitus pressure ulcers.
4. Head support - positions head erect.



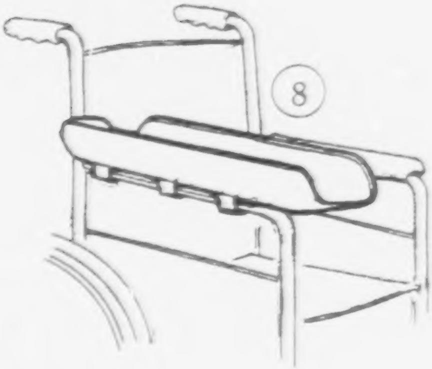
5. Lateral supports attach to the wheelchair to align trunk.



6. Hemisling - supports a paralyzed arm to prevent subluxation.



7. Suspension sling - removes weight of the arm to allow weak muscles to work. Resident may need training to be functional.

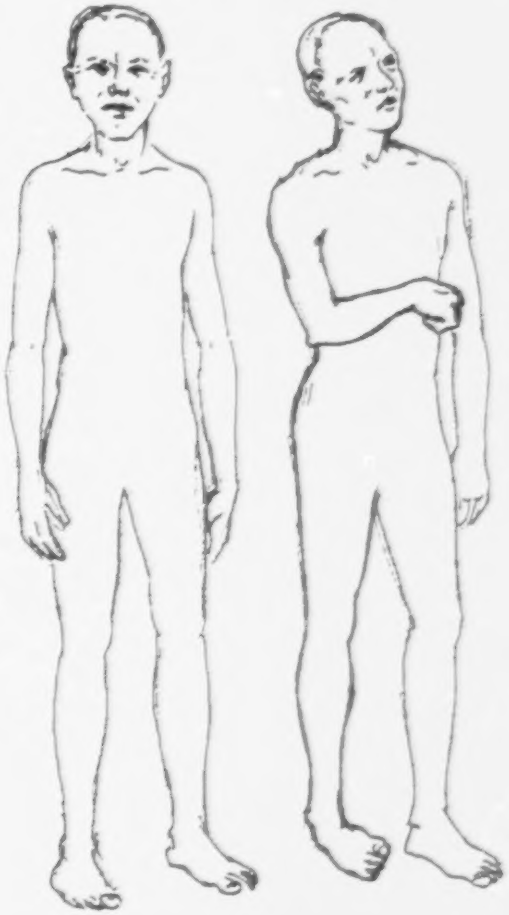


8. Arm trough - positions the hemiplegic shoulder and arm to prevent injury and a painful shoulder.

# Activity: Positioning Techniques

Directions: With the assistance of your partner, assume the standing and lying positions described below. Answer the questions and discuss each related point with your partner and then with the group at the conclusion of the activity. Help your partner assume the positions as he/she goes through the activity.

**Standing Position**



Assume the typical posture of a stroke patient, as pictured.

a. Stand up

b. Turn your head to the left, tilt your neck to the right.

c. On your right side: turn palm down, clench your fist, bend your elbow, and put your hand next to your stomach.

d. On your right side: point toes down, turn the sole of your foot to the left, and straighten the knee.

e. Move your right leg to the left and rotate it inward.

f. On your right side: pull pelvis up and back; shoulders down and back.

Question: In this posture, strongly contract or tighten your muscles for one minute. How does it feel (i.e., was it comfortable?) ?

Point: The typical posture of the hemiplegic is abnormal and uncomfortable. As a general principle, the stroke patient should be positioned away from spastic pattern. For example, the affected side of the trunk should be positioned even with or slightly ahead of the unaffected side.

Question: In this posture, try reaching in different directions; right, left, forward, up, and down. Did you feel as stable as you usually do in standing?

Point: In the hemiplegic posture you are less stable than normal posture. Most of your weight is taken only on one foot.

---

**Side-Lying Position**

These activities demonstrate how postion of one part of the body affects position of other parts, and how proper positioning and comfort correspond.

Question: Lie on your side with your shoulder directly beneath you. Notice the feeling. Now change your position to the way you normally lie on your side. Which was more comfortable for your shoulder?

Point: It is uncomfortable to lie directly on your shoulder. Normally in side-lying your bottom shoulder is slightly anterior to the rest of your body.

Question: Lie on your side again. Is the upper side of your trunk longer or shorter than the lower side? Now place a pillow or blanket roll under your trunk. What happens to the sides of your trunk?

Point: Side-lying promotes lengthening of the lower side of the trunk. This is another reason why positioning on the affected side is preferable. When a resident is positioned on his unaffected side, placing a pillow or blanket roll under his trunk will combat shortening of the upper side, making both sides of the trunk nearly equal in length.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-6 OR DEMONSTRATION:

SELF-CARE SKILLS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify key principles of compensatory self-care techniques.
2. Identify the rationale used to position the resident during self-care activities.
3. List possible adaptations used in fastening buttons, tying shoes, brushing teeth, combing hair, and shaving.
4. Recognize three compensations for perceptual and cognitive deficits in self-care activities.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: One-Handed Shoe Tying Method
2. HO 2: Activity: Self-Care Skills

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987. Review Unit V, "Personal Care."

REFERENCES: (Instructor's Additional Information)

Gee, Z.L. and Passarella, P.M. Nursing Care of the Stroke Patient. 1985.

Up and Around, A Booklet to Aid the Stroke Patient. Distributed by the American Heart Association, 1975.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

INTRODUCTION:

One responsibility as a RNA is to provide opportunities for the residents in your care to maximize functional independence and prevent loss of existing abilities. This includes, but is not limited to: self-feeding, grooming, hygiene, use of adaptive self-help devices, dressing, buttoning, and tying shoes. You will be working closely with the nursing staff and occupational therapist in this aspect of resident care. In this lesson, basic concepts of self-care retraining will be introduced. As you will find, the successful completion of routine self-care activities can be extremely rewarding for the resident.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

OUTLINE: (Key Points)

I. Key Principles of Compensatory Self-Care Techniques

   A. Consider physical abilities

      1. Sitting balance is required to put on a shirt, don socks and shoes.

      2. Sensory losses and neglect of the affected side decrease awareness of body parts.

      3. Abnormal muscle tone may worsen with physical exertion.

   B. Encourage use of weak muscles and/or affected body part. (II-1)

      1. Approach from less functional side of body.

      2. Strive for bilateral use of extremities.

      3. Position nonfunctional arm.
         Example: When washing the face, both hands should be placed on the sink.

   C. Promote normal movement patterns.

      1. Perform ADL in an upright position.

      2. Assist the resident to assume a good posture while completing ADL. (Best to sit in a wheelchair or straight-back chair with arms.)

   D. Provide correct amount and type of assistance.

      1. Amount of assistance

         a. Too little assistance results in excessive efforts and frustration.

         b. Too much assistance results in dependent behavior. (II-2)

      2. Type of assistance

         a. Verbal directions must be clear and concise.

         b. A consistent routine and repetition is essential.

c. Be aware of safety factors and precautions to prevent injury.

E. Relay information about resident's abilities and capabilities to other staff to develop consistent expectations of the resident through continuity of care.

1. Therapy consultant (II-3)

2. Other Certified Nurse Assistants

3. Charge nurse

II. Positioning Can Influence Self-Care Abilities

A. Performing self-care activities while in upright position is therapeutic.

1. Forces the resident to use muscles to maintain erect posture .

2. Promotes weight shifts which leads to normalized balance

3. Strengthens muscles and builds endurance (II-4)

B. Check for proper body alignment:

1. Head should be erect, shoulders equal in height (symmetrical).

2. Wheelchair or chair should support the weight of the body on buttocks and thighs.

3. Arms should be supported on a lapboard or arm trough.

4. Back straight against back of chair, as should be hips and buttocks.

5. Hips and knees should be at ninety degrees. (Demonstrate.)

6. Feet should be flat on the floor or resting on footrests of wheelchair.

C. Positioning devices may be introduced by the therapy consultant:

1. Splints for hands, feet, neck

2. Head support

3. Lapboard, arm support, or sling

4. Pillows, rolls, sandbag, restraints

D. Carry-over and consistent use of positions and positioning devices is a major role of the RNA.

III. Adaptations for Common Self-Care Problems

**NOTE: Refer again to Handouts 1-3 from lesson 4 of this unit.**

A. Fastening buttons

1. Use of a button aid
2. One-handed buttoning
3. Nylon tape fastener (Velcro™) replaces buttons
4. Buttons sewn on with elastic thread (limited utility)

B. Tying shoes

1. One-handed method (HO 1)
2. Replace shoelaces with elastic laces
3. Nylon tape fastener (Velcro™) closures attached to lace shoes

C. Brushing teeth/denture care

1. Suction cup denture brush for one-handed cleaning
2. Rechargeable power toothbrush
3. Pump dispenser toothpaste
4. Built-up handles or universal cuff to secure brush in hand
5. Complete task at sink if possible to reinforce normal routine

D. Combing hair

1. Bilateral use of hands to hold brush/comb
2. May need extended, angled handle on brush to compensate for strength or range limitations

E. Shaving

1. Use of electric razor if weakness or sensory deficit is present.

2. Bilateral use of hands to stabilize razor

3. Blow up cheeks to make beard stand up

4. May miss areas of face due to sensory loss or visual deficits (II-5)

5. If possible, stand at sink in front of a mirror to promote normal routine.

IV. Compensating for Perceptual and Cognitive Deficits

A. Compensation for perceptual and cognitive deficits can be promoted by helping the resident establish a routine, practicing the same pattern day after day until it becomes automatic.

B. Compensating for poor body part awareness:

1. Use a mirror while dressing.

2. Before beginning dressing procedure, position garment to avoid confusion.

3. Use touch and verbal cues (i.e., "Put one hand up, then the other.").

4. Don't use words "left" and "right". Point or refer to body part by location (i.e., the foot next to the bed).

5. Mark the right shoe, splint, etc. with colored tape or laundry pencil.

C. Figure ground problems - unable to distinguish between foreground and background

1. Arrange meal tray so that it has only a few items.

2. Organize drawers, separate articles of clothing.

3. Make signs and other written materials with sharp contrasts such as black and white.

D. Difficulty in judging spatial relationships may cause the resident to bump into doorways or objects.

1. Slow down impulsive behavior and actions. (II-6)

2. Practice a task until it becomes automatic (i.e., driving the wheelchair from dining room to activity room).

3. When buttoning a shirt, start at bottom of shirt to avoid confusion.

E. Problems with sequencing means the resident does not know the order of events required to complete an activity.

1. Visual cues such as labels, posters, or charts with diagrams may help outline the steps.

2. Break down a task into steps, and introduce one step at a time until resident is successful.

3. Use the same sequence of steps each practice session. Practice until it becomes automatic.

V. Summary and Conclusion

A. Key principles of compensatory self-care techniques

B. Positioning can influence self-care abilities

C. Adaptations for common self-care problems

D. Compensating for perceptual and cognitive deficits

You will spend many hours at work assisting the resident in relearning self-care skills. After working with the occupational therapist and other therapy consultants on a variety of resident cases, you will become more familiar with the numerous compensatory techniques.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

INTERACTION ITEMS:

1. How does approaching from the weak side encourage a resident to compensate for sensory and visual losses?
2. How can a resident's actions alert you to the need to alter the amount of assistance you are giving?
3. What are some ways to relay such information to each team member?
4. While sitting, bend over and touch your toes for three seconds. What are the effects to back muscles, balance, respiration, and feelings?
5. What technique would you use to show the resident the need to correct his/her errors?
6. What is an example of such behavior you may have seen?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students use Handout 2: Activity: Self-Care Skills to reinforce the information presented in this lesson.

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

EVALUATION ITEMS:

1. Key principles of compensatory self-care techniques include: (Circle the letter of the best answer.)

   a. Promote normal movement.
   b. Relay information to other staff.
   c. Provide correct type/amount of assistance.
   d. All of the above.

2. Sitting up to complete ADL is beneficial to the resident because: (Circle the letter of the best answer.)

   a. It forces the resident to use weak muscles.
   b. It saves time for the nursing staff.
   c. The resident enjoys the attention he/she receives.
   d. It contributes to decubitus ulcer formation.

For each self-care task, list one adaptation or compensatory technique:

3. Shaving ____________________

4. Combing hair ____________________

5. Tooth/denture care ____________________

6. Tying shoes ____________________

7. Buttoning ____________________

8. One compensation for inability to judge spatial relationships might be: (Circle the letter of the best answer.)

   a. Use a button aid.
   b. Make a poster.
   c. Use a mirror in dressing activities.
   d. Train resident to work slower.

9. Utilizing written material with sharp contrasts is a compensation for: (Circle the letter of the best answer.)

   a. Poor sequencing
   b. Impaired body awareness
   c. Figure ground problems
   d. Muscle weakness

10. Positioning of a non-functional, flaccid arm may require: (Circle the lettter of the TWO best answers.)

- a. A splint
- b. A sandbag
- c. A lapboard
- d. A wheelchair

LESSON PLAN: 6

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

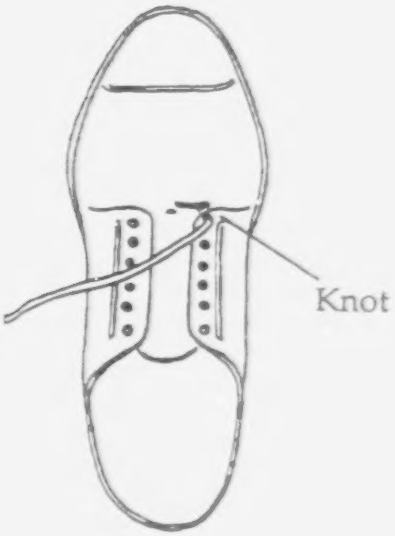
ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. The student may list one of the following: use an electric razor; bilateral use of hands to stabilize razor; blow up cheeks to make beard stand up
4. The student may list one of the following: bilateral use of hands to hold brushcomb; use extended, angled handle on brush to compensate for strength or range limitations
5. The student may list one of the following: suction cup denture brush for one-handed cleaning; rechargeable power toothbrush; pump dispenser toothpaste; built-up handles or universal cuff to secure brush in hand
6. The student may list one of the following: one-handed tying method; replace shoelaces with elastic laces; nylon tape fastener (Velcro™) closures
7. The student may list one of the following: use of a button aid; one-handed buttoning; nylon tape fastener (Velcro™) replaces buttons
8. d
9. c
10. a and c

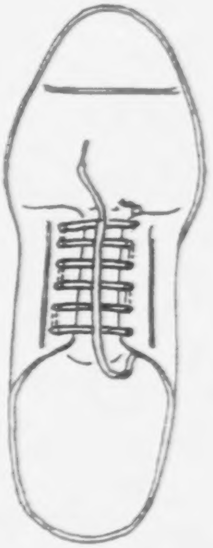
HO 1

# One-Handed Shoe Tying

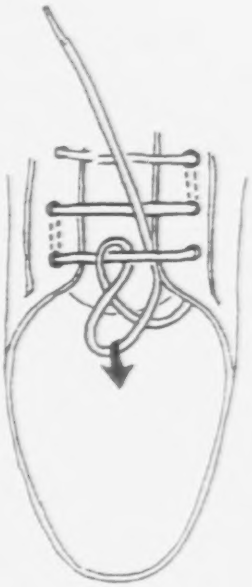
## Method



Step 1



Step 2



Step 3

1. Knot one end of the shoestring and pull through at the lowest eyelet; continue lacing shoes as indicated.

2. When you reach the last eyelet, the string goes from outside to inside and then is positoned over the top of the lace.

3. Make a loop at the free end of the shoe lace and pull it loop within a loop as shown in Step 3.

4. Pull the lace tight being careful not to pull the free end all the way through.

5. To untie, pull the free end.

# Activity: Self-Care Skills

These activities are designed to guide you in understanding movements normally performed as we dress and how varying positions can influence dressing.

Activity 1

Sit in a chair with your feet flat on the floor. Reach for your feet. Now sit in a chair with your legs crossed and reach for your feet. Which way felt more stable?

Point

You are less stable when sitting with your legs crossed. To put on shoes, socks, and pants, the resident must cross one leg over the other. Because she/he is less stable in this position, guard her/him closely. The resident will be more likely to lose her/his balance than when she/he is sitting upright in the chair with legs uncrossed.

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Activity 2

Sit in a chair with your feet flat on the floor. Reach as far to the side as you can. Now sit on the side of an elevated bed with your feet off the floor. Reach as far to the side as you can. Which way felt more stable?

Point

When dressing the resident should sit in a chair with both feet on the floor. This position is much more stable.

---

Activity 3

Try to button a shirt and to zip and unzip a zipper using only one hand. Was it easier or more difficult than using two hands? Did it take longer than using two hands?

Point

Getting dressed will be difficult, time-consuming process for the hemiplegic. While he/she is initially learning to do so, you may need to do parts of the activities for him/her, so provide assistance as the resident does what he/she can.

LESSON PLAN: 7

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-7 OR DEMONSTRATION:

COGNITIVE LOSS: COMPENSATION AND ADAPTATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify cognitive loss factors which vary from resident to resident.
2. Name three general principles to follow when introducing a new activity to a resident who has cognitive/perceptual limitations.
3. Identify key points related to sensory stimulation techniques.
4. Identify specific cognitive losses associated with specific compensation or adaptation measures.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Siev, E., et. al. Perceptual and Cognitive Dysfunction in the Adult Stroke Patient. Thorofare, NJ: Slack Incorporated, 1986.

Ross, M and D. Burdick. Sensory Integration. Thorofare, NJ: Slack Incorporated, 1981.

INTRODUCTION:

You have already learned about cognitive and memory limitation. Now you should be ready to learn common methods of turning disability into ability. The RNA is responsible for carry-over of the restorative procedures to the resident's daily routine.

LESSON PLAN: 7

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

OUTLINE: (Key Points)

I. Cognitive Loss Factors Which Vary From Resident to Resident

- A. Location/extent of brain damage
  - 1. Post CVA/head injury can regain some skills if another area of the brain can compensate or "take over" those functions.
  - 2. Damage in certain parts of the brain may make it impossible for new learning to occur, as in some forms of cerebral palsy or mental retardation.
- B. Progressive deterioration of the nervous system, as caused by degenerative disorders such as multiple sclerosis, Parkinson's, Alzheimer's, to name a few.
- C. Medications
- D. Environment (II-1)
- E. Age/personality of the resident
- F. Physical problems - can decrease one's ability to process and register information.
  - 1. Pain
  - 2. Fatigue
  - 3. Sensory loss

II. Key Principles for Working With the Resident With Cognitive/Perceptual Limitations

- A. Establish a calm environment; maintain a positive attitude; avoid pressuring for performance.
- B. Switch slowly from one task to another.
- C. Maintain firm kindness to foster the resident's sense of security.
- D. Simplify the environment; reduce distractors. (II-2)

E. **Break down new tasks into small steps; provide visual cues, gestures, and demonstrations.**

F. Slow down an impulsive pace to insure the resident's safety.

G. Use nonverbal communication to provide constant feedback.

H. Identify the resident's cognitive strengths and capabilities and focus on them.

III. Sensory Stimulation

A. Defined as treatment which systematically focuses the resident's attention to each of the senses.

B. Beneficial to cognitive skills

1. Reduces the effects of sensory deprivation
2. Rekindles interest in the environment
3. Increases attention during self-care tasks
4. Decreases confusion and disorientation

C. Stimulate each sense by introducing and talking about the method of stimulation; progress to more resident participation.

1. Olfaction - perfumes or spices; lemon and other pungent fruits; coffee (II-3)
2. Vision - mirror; colorful designs; identify objects, identify resident in photographs
3. Auditory - music, radio, animals, instrument sounds that are loud/soft, fast/slow, pleasant/unpleasant
4. Tactile - warm and cool water; massage; make bread; tend plants; self-grooming
5. Gustatory - foods that are sweet/salt/sour; chewy; smooth/hard

IV. Functional Compensations or Adaptations

A. Poor attention - unable to receive information from the environment and attend to it. May be due to decreased alertness or distractibility

1. Provide surroundings with limited noise, people, objects. Progress by adding more stimuli over time. (II-4)

2. Have the resident vocalize the steps to the task.

3. Provide feedback to change resident's behavior.

4. Start with short-term tasks with concise directions.

B. Perseveration - inability to shift attention in order to change or stop a behavior; resident "gets stuck" in an automatic response repeating an action or thought over and over

1. Cue or provide feedback to resident using touch.

2. Introduce or substitute another action.

3. Change the physical environment.

C. Memory loss or impairment

1. Maintain consistent and repetitive routine from day to day.

2. Make a list of the daily activities/locations as a reminder. Timetables, diaries, and daily plans may be helpful.

3. Label bathroom door, dresser drawers to show contents, etc.

4. Introduce mnemonics, visual imagery, or other internal aids as suggested by the therapy consultant.

D. Lack of initiation - difficulty starting a task can be exhibited by slowness of response and decreased spontaneity

1. Environment can affect performance. Use verbal cues that decrease over time.

2. Assist resident in developing an awareness of the problem by giving feedback.

3. Controlled sensory input (i.e., touch and movement of the resident's arm combined with verbal coaching is used to cue resident to initiate putting on his/her shirt).

E. Poor sequencing - inability to know the order of steps in a task

1. Structure the environment to reflect the order of steps in a task.

2. Provide posters, cue cards, reminders as to steps in daily living tasks.

3. Practice, practice, practice, until steps become automatic.

4. Offer various activities which require this ability, start with two or three steps, make tasks more complex over time. (II-5)

V. Summary and Conclusion

A. Cognitive loss factors which vary from resident to resident

B. Key principles for working with the resident with cognitive/perceptual limitations

C. Sensory stimulation

D. Functional compensations or adaptations

Environmental modification, gentle but firm feedback, patience with providing a consistent and repetitive routine, and focusing of capabilities will help the resident with cognitive loss function at a maximum capacity. These techniques will also help offset the debilitating effects of illness and institutionalization.

LESSON PLAN: 7

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

INTERACTION ITEMS:

1. How might the environment hinder a person's performance when attention is poor?

2. How would you translate the rule, "Simplify the environment" when preparing for a treatment session?

3. Name a pleasant odor; an unpleasant one. What type of response would you expect after introducing the unpleasant odor?

4. How would poor attention affect a treatment session? Performing a transfer from wheelchair to a bed?

5. Would someone with poor sequencing ability ever be able to relearn how to button a shirt or use the telephone independently?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 7

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE PROCEDURES

EVALUATION ITEMS:

1. All of the following factors account for the variability of cognitive loss in the LTC population EXCEPT: (Circle the letter of the best answer.)

   a. Physical problems
   b. Race and religion
   c. Progressive deterioration of the nervous system
   d. Location/extent of brain damage

2. When introducing new activities to the resident with cognitive limitations, it is best to do all of the following EXCEPT: (Circle the letter of the best answer.)

   a. Break the task into small steps
   b. Use gestures and visual cues
   c. Speak loudly to be sure you are understood
   d. Reduce the distractors in the room

3. Constant feedback to the resident can be: (Circle the letters of the **TWO** best answers.)

   a. A nod of the head to show approval
   b. Reading the steps to the activity just as the therapist wrote them
   c. A reassuring pat on the back
   d. Extending the treatment session by 10 minutes

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 4. Sensory stimulation is done to help the resident feel hot, cold, sharp, dull more accurately.

____ 5. Stimulation using the sensory systems should never involve resident participation.

____ 6. Taste, touch, and vision are all sensory systems used in stimulation.

____ 7. Providing a variety of sensations seems to be important in sensory stimulation treatment.

8. Taping a picture of socks and underwear to the front of the resident's top dresser drawer is an example of compensation for: (Circle the letter of the best answer.)

   a. Poor sequencing
   b. Poor initiation
   c. Poor memory
   d. Perseveration

9. Mrs. Talbot has a poster in her room which lists six steps in putting on her shirt and slacks, complete with photographs of her doing the dressing tasks. One might assume she is working on a cognitive deficit in the area of: (Circle the letter of the best answer.)

   a. Poor attention
   b. Poor sequencing
   c. Poor memory
   d. Could be any of all of the above

10. Mrs. Elmore can brush her teeth independently but often perseverates the step of rinsing out her mouth. The RNA might: (Circle the letter of the best answer.)

   a. Never let her brush her teeth independently.
   b. Supervise daily; guide her cup-holding hand through the motion of returning the cup when the repetition is noticed.
   c. Color code her toothbrush and cup.
   d. Simplify the environment by asking her roommate to leave while Mrs. Elmore brushes her teeth.

LESSON PLAN: 7

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. b
2. a, b and d
3. a and c
4. F
5. F
6. T
7. T
8. c
9. d
10. b

LESSON PLAN: 8

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-8 OR DEMONSTRATION:

ASSISTING RESIDENTS WITH SWALLOWING DISORDERS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List the four phases of the swallowing process in the correct order.
3. Identify signs of aspiration.
4. Identify procedures used in swallowing therapy.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Four Phases of Swallowing

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

REFERENCES: (Instructor's Additional Information)

Logemann, J. Evaluation and Treatment of Swallowing Disorders. San Diego: College-Hill Press, Inc., 1983.

Logemann, J. Manual for the Videofluorographic Study of Swallowing. San Diego: College-Hill Press, Inc., 1982.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

Steefel, J.S. Dysphagia Rehabilitation for Neurologically Impaired Adults. Springfield: Charles C. Thomas, 1981.

INTRODUCTION:

As you learned in a previous unit, difficulty swallowing is called "dysphagia." Individuals with dysphagia may need special feeding considerations in addition to or instead of the usual mealtime routine. If a resident has a swallowing problem that can be treated behaviorally, often a special pathologist is consulted to develop a plan of swallowing therapy for that resident. The restorative nurse assistant may be called upon to assist residents in their swallowing program once the maintenance phase of therapy has begun. For this reason it will be important for you to become familiar with normal swallows, signs of trouble during a swallow and the types of procedures used in swallowing therapy.

LESSON PLAN: 8

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Bolus - food which has been chewed

  B. Cricopharyngeal sphincter - muscle which allows food to pass from throat to esophagus

  C. Esophagus - digestive canal leading from the throat to the stomach

  D. Peristalsis - squeezing movement of esophagus which propels food to the stomach

  E. Pharyngeal - of the throat

  F. Velum (soft palate) - located at the back of the mouth; closes off the nasal cavity during swallowing

II. Normal Swallowing Process (TM 1) (II-1)

  A. Oral prepatory phase

    1. Food is chewed.

    2. A bolus is formed.

  B. Oral phase

    1. Tongue moves bolus back.

    2. Lips are pressed together to prevent leakage.

  C. Pharyngeal phase

    1. Swallowing reflex is triggered.

    2. Voluntary swallow is also in effect.

    3. Velum closes to prevent food from going into nose.

    4. Food goes down into the pharynx.

    5. Larynx closes to keep food out of lungs.

    6. Cricopharyngeal sphincter relaxes to allow material to pass to esophagus.

D. Esophageal phase

  1. Lasts 8 to 20 seconds

  2. Bolus is moved by peristalsis to stomach.

III. Aspiration During the Swallowing Process (II-2)

A. Many residents are silent aspirators, showing no outward signs of aspiration. This is one reason for obtaining a videofluoroscopic evaluation of the swallowing process.

B. Common signs of aspiration

  1. Resident's voice sounds wet and gargley after swallowing.

  2. Resident coughs reflexively.

  3. Resident spits up material when he/she coughs after swallowing.

IV. Therapeutic Management of the Swallowing Process

A. The speech pathologist will prepare a plan for the resident if the dysphagia is to be managed with behavioral techniques.

B. These techniques might include: (II-3)

  1. Oral exercises to strengthen the lips, tongue, and swallow reflex

  2. Tilting the head forward

  3. Turning the head sideways

  4. Thermal stimulation

  5. Posture changes

  6. Voluntarily coughing after swallowing to make sure vocal cords are clear and no food will accidentally slide down into the lungs

  7. Saying a short phrase after swallowing to make sure voice is clear and therefore, the vocal cords are clear

  8. Holding breath during swallow

V. Summary and Conclusion

A. Terms and definitions

B. Normal swallowing process

C. Aspiration during the swallowing process

D. Therapeutic management of the swallowing process

This lesson has given us some basic information regarding swallowing. It is important to remember that the evaluation and treatment of dysphagia requires a team effort. The success of dysphagia therapy is vitally important not only to the resident's health, but also to the resident's quality of life. Your role may sometimes include helping a resident follow his/her exact procedure for achieving a successful swallow under the supervision of a speech pathologist once the maintenance phase of swallowing therapy has begun.

LESSON PLAN: 8

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What are the four stages of swallowing?
2. What are three danger signs that a resident is aspirating?
3. What are some behavioral techniques that a speech pathologist might prescribe to manage a swallowing problem?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 8

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

Match the following terms with their correct definitions by writing the appropriate letter in the blank.

___ 1. Of the throat

___ 2. Digestive canal leading from the throat to the stomach

___ 3. Food which has been chewed

___ 4. Squeezing movement of esophagus which propels food to the stomach

___ 5. Muscle which allows food to pass from throat to esophagus

___ 6. Located at the back of the mouth; closes off the nasal cavity during swallowing

a. Peristalsis

b. Cricopharyngeal sphincter

c. Esophagus

d. Velum

e. Pharyngeal

f. Bolus

List the four phases of the swallowing process in the correct order.

___ 7. Esophageal phase

___ 8. Oral prepatory phase

___ 9. Pharyngeal phase

___ 10. Oral phase

a. Phase 1

b. Phase 2

c. Phase 3

d. Phase 4

For each of the following, write "T" if the statement is true, or "F" if it is false.

___ 11. If a resident's voice is gargley or wet after swallowing, he/she is probably aspirating.

___ 12. Tilting the head forward or sideways improves a resident's swallow.

___ 13. If a resident does not cough after swallowing, then she/he is not aspirating.

___ 14. It is a good idea for a dysphagic resident to talk after each swallow to make sure food has been cleared from the vocal cords.

LESSON PLAN: 8

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

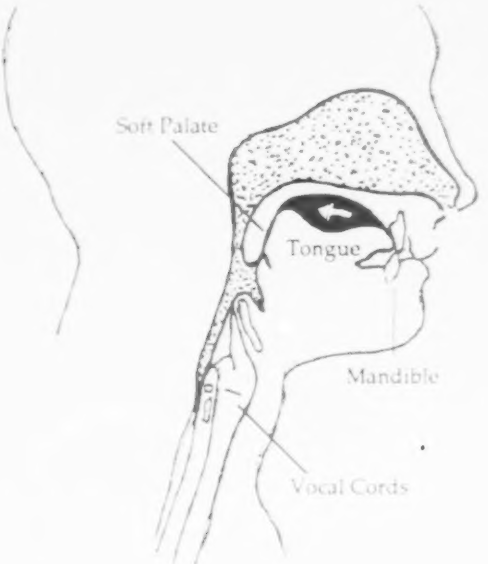
UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

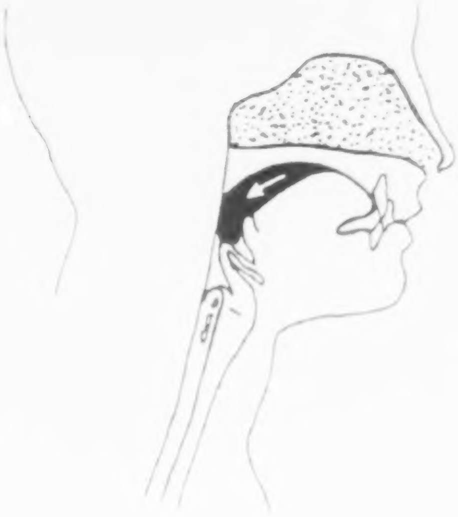
1. e
2. c
3. f
4. a
5. b
6. d
7. d
8. a
9. c
10. b
11. T
12. T
13. F
14. T

TM 1

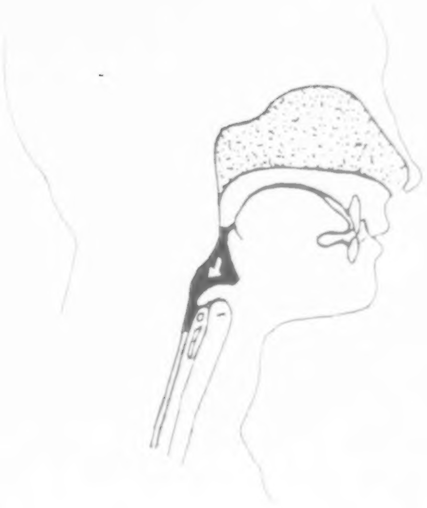
# Four Phases of Swallowing


Soft Palate
Tongue
Mandible
Vocal Cords

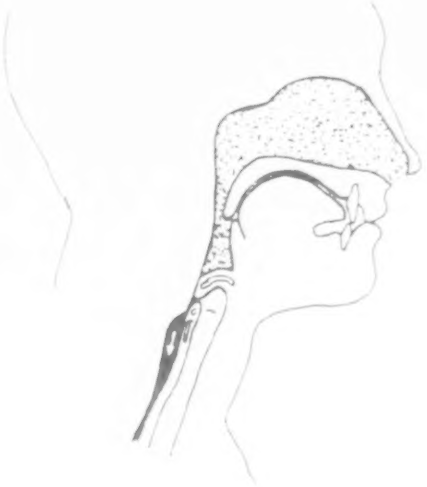
1. Oral Preparatory Phase



2. Oral Phase and First Part of Pharyngeal Phase



3. Pharyngeal Phase



4. Esophageal Phase

LESSON PLAN: 9

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-9 OR DEMONSTRATION:

## ALTERNATIVE COMMUNICATION METHODS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify ways to help dysarthric residents communicate more effectively.
3. Identify precautions necessary for resident who has had a laryngectomy.
4. Identify ways in which the resident who has had a laryngectomy can communicate.
5. List four methods of alternative communication other than speech.
6. Identify uses for the various methods of alternative communication.
7. Identify ways to help severely speech/language impaired individuals to use their alternative communication methods.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Examples of Electronic Communication Devices
2. HO 2: Examples of Communication Boards
3. HO 3: Examples of Amer-Ind Gestural Code

INFORMATIONAL ASSIGNMENT:

Review Unit VI, Lesson 3 entitled "Aphasia and Apraxia" and Lesson 4 entitled "Dysarthria and Laryngectomy."

REFERENCES: (Instructor's Additional Information)

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INTRODUCTION:

There are communicatively handicapped individuals for whom speech is not functional or reliable enough for communication. These individuals often need an alternate system for communicating instead of or in addition to speech. In these cases it is important to remember that speech is not the only method of communication. Very often other means of conveying messages work better than speech. As an RNA you should be aware of these alternate systems in order to help your residents communicate most effectively.

LESSON PLAN: 9

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions

A. Alternative - another choice

B. Electronic - using electricity or batteries

C. Sign language - using hands to convey messages

D. Graphic - use of drawing or writing

E. Communication - getting messages and ideas across to a listener

II. Helping Dysarthric Residents Communicate

NOTE: **Always follow specific recommendations made by the speech pathologist. Some of the recommendations may include:**

A. If speech is too fast ask the resident to slow down.

B. Ask the resident to say one word at a time.

C. Ask the resident to try to exaggerate his/her words.

D. Encourage resident to speak louder if his/her voice is too soft.

E. Pushing down on the sides of a chair while sitting can sometimes help increase loudness.

F. If you didn't understand what the resident said, ask him/her to say it in a different way.

G. Be sure to watch resident's face while talking with him/her to observe all available visual cues.

III. Caring For/Communicating with Residents with Laryngectomies

A. Laryngectomy - surgical removal of all or part of the larynx

1. Partial laryngectomy - only vocal cords are removed; tracheostomy (stoma) is closed within several days

2. Removal of entire larynx along with thyroid cartilage and epiglottis creates permanent need

for tracheostomy so resident can breathe.

3. Laryngectomees (persons who have had laryngectomies) may use an electrolarynx to speak; voice prostheses requires an extra puncture above the stoma.

B. Care and precautions

1. Laryngectomees should wear stoma covers to prevent excess dust and debris from entering the stoma.
2. When showering or bathing a cloth or stoma guard should be worn to protect the stoma from water.
3. Food, liquid, and medicine should not go into the stoma.
4. Plastic or cellophane should never be used to cover a stoma.
5. Laryngectomees should not go swimming.
6. Be careful when cleaning area around the stoma to make sure that no water leaks into the airway.
7. Laryngectomees may need to sleep with a humidifier to keep the stoma from drying out.

B. Tips for communicating with the laryngectomee

1. Be patient; give the resident time to speak with his/her new method of speech.
2. Remind the resident to speak slowly and to pause between phrases.
3. Give resident feedback telling him/her what you understood and what you didn't understand.
4. At the request of the speech pathologist you might encourage the resident to practice the new method of speech for a short period of time each day at first.

IV. Residents Who May Benefit From Alternative Communication Devices

A. Residents with severe dysarthria due to CVA, head injury, progressive disease, etc.

B. Residents with aphasia and/or apraxia having nonfunctional speech or severely limited verbal output

V. Alternative/Augmentative Communication Devices

A. Electronic devices with speech output (HO 1) (II-1)

1. Computerized - some devices are like computers in which phrases and words can be programmed for the individual resident. After programming the resident merely presses a button to select the phrase he/she wants to say.

2. Recorded - some devices contain prerecorded messages for communicating basic wants and needs such as "I need help." Resident activates the machine by pressing a button to select the phrase he/she wants to convey.

B. Communication boards (HO 2) (II-2)

1. Communication boards vary in sophistication from cardboard to plexiglass; user points to or otherwise selects symbols, letters, words, phrases, etc. that will convey the desired message to the listener.

2. Types of communication boards

a. Picture board - for nonreaders to communicate wants and needs

b. Word/phrase board - for readers with common words and phrases for resident to point to

c. Spelling board - contains letters of the alphabet for resident to spell out messages by pointing

d. Eye-gaze board - contains pictures, letters, or phrases in groups so resident who is unable to point can indicate wants and needs by looking at the necessary picture, letter, or phrase

e. Symbol board - some residents are able to learn a system of abstract symbols and to combine them into messages

VI. Gestural Communication (II-3)

A. Amer-Ind gestural code - a system of simple, easy-to-read signs based on American Indian hand talk (HO 3)

B. American sign language - sign language of the deaf; very complex and more difficult to learn for brain injured residents; also more difficult to understand for the listener

C. Pantomime - acting out activities, needs, etc.

VII. Graphic Communication (II-4)

A. Drawing pictures to symbolize the message to be communicated

B. Writing - writing key words, letters, phrases, etc. to communicate

VIII. Ways the RNA Can Help the Communicatively Handicapped(II-5)

A. Above all, be patient! Remember the resident may have trouble adjusting to an alternate method of communication. It takes time.

B. Encourage resident to initiate communication instead of just answering questions all the time.

C. Based on the resident's speech therapy plan, encourage him/her to use all communication options if speech breaks down. Suggest using the alternative methods recommended by the speech pathologist.

D. Stay in close contact with the speech pathologist to make sure you know the resident's abilities. For example, you may need to know whether or not the resident can read. Whether he/she can use arms and hands to gesture, how much he/she can understand, etc.

E. Remember that just because a person cannot speak or has trouble speaking does not mean he/she cannot communicate.

F. Treat the communicatively handicapped with respect. Don't talk about the resident in front of him/her thinking he/she can't understand you.

G. Maintain a positive, encouraging attitude. This will help the communicatively handicapped resident as well as other residents and staff accept the alternative communication method.

H. Encourage the resident who is using an electronic device or communication board to take it with him/her to all activities.

IX. Summary and Conclusion

A. Terms and definitions

B. Helping dysarthric residents communicate

C. Caring for/communicating with residents with laryngectomies

D. Residents who may benefit from alternative communication devices

E. Alternative/augmentative communication devices

F. Gestural communication

G. Graphic communication

H. Ways to help the communicatively handicapped

Learning to communicate in ways other than by speech is often a long and difficult process. However, it is important to be aware of the various options available to persons with nonfunctional speech. Our acceptance of these alternatives and our willingness to encourage residents to use them can make a big difference in the quality of life for our severely speech/language disordered residents.

LESSON PLAN: 9

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What types of electronic devices are available for residents with severe speech/language impairments?

2. What are some abilities residents would need to use the various types of communication boards?

3. What are some types of gestural communication?

4. How could a resident communicate with pencil or paper?

5. What are some ways that you might help a resident who must use alternative communication?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students pair off and take turns trying to communicate with communication boards, through gestures, or by using paper and pencil. Allow students time to discuss what it felt like when they used these methods to send messages, then describe how it felt as the receiver.

LESSON PLAN: 9

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the appropriate letter in the blank.

___ 1. Getting messages and ideas across to a listener

___ 2. Using hands to convey messages

___ 3. Using electricity or batteries

___ 4. Use of drawing or writing

___ 5. Another choice

a. Graphic

b. Communication

c. Alternative

d. Electronic

e. Sign language

6. Which three of the following techniques are helpful when trying to assist dysarthric residents in communicating more effectively? (Circle the letters of the three correct answers.)

   a. Ask resident to talk faster.
   b. Have the resident say one word at a time.
   c. Ask the resident to say it in a different way.
   d. Have the resident talk more softly.
   e. Watch the resident's face.
   f. Ask the resident to say a whole sentence before taking a breath.

For each of the following, write "T" if the answer is true, or "F" if it is false.

___ 7. Laryngectomees should wear covers over their stomas while swimming.

___ 8. Laryngectomees can eat by mouth or through their stoma.

___ 9. Sleeping with a humidifier is good for helping keep a stoma moist.

___ 10. Stoma covers should be worn to protect stomas from dust and debris.

___ 11. Laryngectomees have had their vocal cords removed and will always have to write or gesture to communicate.

___ 12. Laryngectomees breathe through a hole in their necks.

___ 13. Laryngectomees may use an electrolarynx to speak.

___ 14. A voice prosthesis requires an extra puncture above the stoma.

___ 15. When helping a laryngectomee to speak again you should encourage him/her to practice several hours at a time to build up stamina.

16. List four major methods of alternative communication other than speech.

a.

b.

c.

d.

For each of the following, write "T" if the statement is true, or "F" if it is false.

___ 17. Encourage the resident to use all his/her communication options according to his/her speech therapy plan.

___ 18. Talk to other people in the resident's presence about how he/she is not using the alternative communication devices as well as possible. This should motivate the resident to try to do better.

___ 19. Do not try to use a phrase board with a resident who cannot read.

___ 20. Encourage the resident to initiate conversation with the alternative communication methods.

___ 21. Be sure the resident leaves all communication devices and boards in his/her room for safekeeping when attending activities.

___ 22. Drawing or writing could be good alternative methods for residents with severe dysarthria.

___ 23. A picture board would be an appropriate method of communication for a speech/language impaired person who is nearly blind.

___ 24. An eye-gaze communication board would be useful for a speech/language impaired resident with total paralysis.

___ 25. Electronic devices often have the feature of voice output.

___ 26. RNA's may be asked to help residents with their alternative communication under the supervision of a speech pathologist.

LESSON PLAN: 9

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

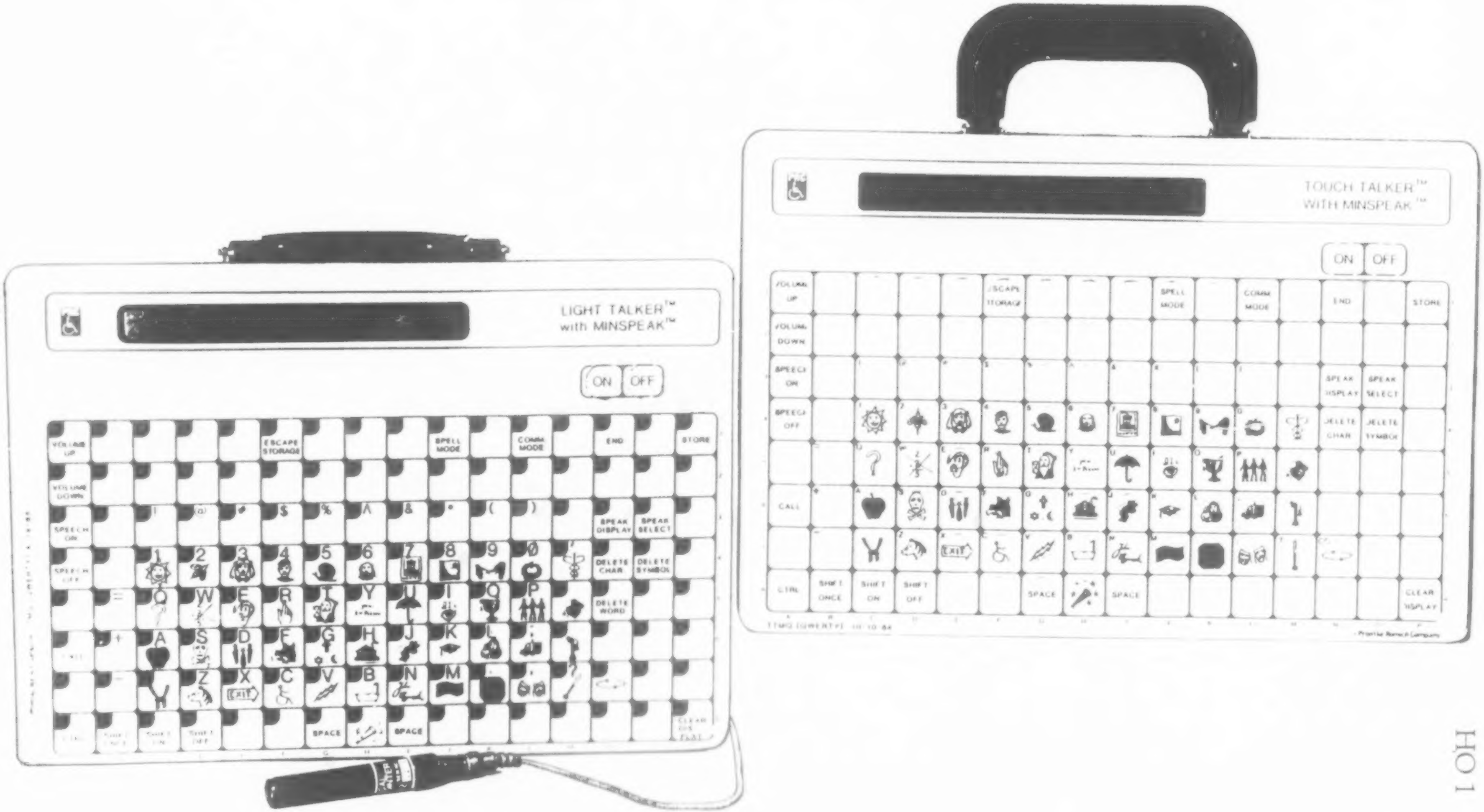
UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1 b
2. e
3. d
4. a
5. c
6. b, c, e
7. F
8. F
9. T
10. T
11. F
12. T
13. T
14. T
15. F
16. a. Electronic devices
    b. Gestural communication
    c. Communication boards
    d. Drawing and writing
17. T
18. F
19. T
20. T
21. F
22. T
23. F
24. T
25. T
26. T

# Examples of

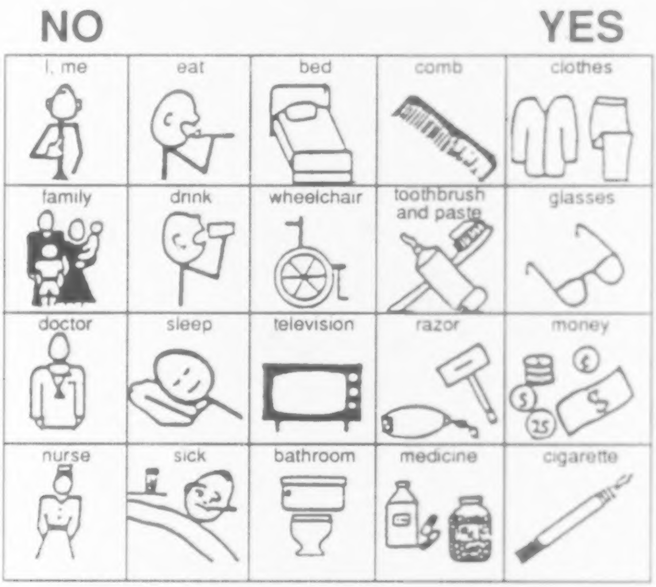
## Electronic Communication Devices


LIGHT TALKER™
with MINSPEAK™
TOUCH TALKER™
WITH MINSPEAK™
ON
OFF

Used with permission Prentke Romich Company

# Communication Boards

## Picture Board


NO
YES
I, me
eat
bed
comb
clothes
family
drink
wheelchair
toothbrush and paste
glasses
doctor
sleep
television
razor
money
nurse
sick
bathroom
medicine
cigarette

## Word Board

| | | |
|---|---|---|
| I CAN HEAR PERFECTLY | PLEASE REPEAT AS I TALK (THIS IS HOW I TALK BY SPELLING OUT THE WORDS) | WOULD YOU PLEASE CALL |
| A AN HE<br>HER I IT ME<br>MY HIM SHE<br>THAT THE THESE<br>THEY THIS WHOSE<br>WHAT WHEN WHERE<br>WHICH WHO WHY<br>YOU WE YOUR | AM ARE ASK BE BEEN BRING CAN<br>COME COULD DID DO DOES DON'T<br>DRINK GET GIVE GO HAD HAS HAVE<br>IS KEEP KNOW LET LIKE MAKE MAY<br>PUT SAY SAID SEE SEEN SEND SHOULD<br>TAKE TELL THINK THOUGHT WANT<br>WAS WERE WILL WISH WON'T WOULD -ED<br>-ER -EST -ING -LY -N'T -'S -TION | ABOUT ALL<br>AND ALWAYS<br>ALMOST AS<br>AT BECAUSE<br>BUT FOR FROM<br>HOW IF IN<br>OF ON OR<br>TO UP WITH |
| A B C D E F G<br>H I J K L M<br>N O P Qu R S T<br>U V W X Y Z<br>1 2 3 4 5 6 7<br>8 9 10 11 12 30 | | AFTER AGAIN<br>ANY EVEN<br>EVERY HERE<br>JUST MORE<br>ONLY SO<br>SOME SOON<br>THERE VERY |
| SUN. MON. TUES.<br>WED. THUR.<br>FRI. SAT. BATHROOM | PLEASE THANK YOU GOING OUT<br>MR. MRS. MISS<br>MOTHER DAD DOCTOR<br>START OVER<br>END OF WORD | $¢½(SHHH!!)?<br>__________ is my Name |

from **Aphasia** by R. Brookshire, BRK Publishers, Minneapolis, 1986
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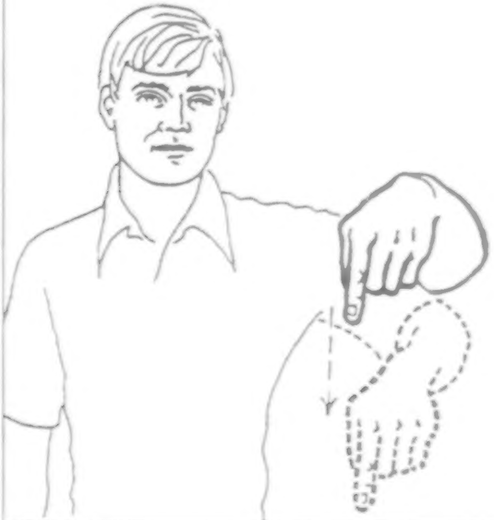
# Examples of
## Amer-Ind Gestural Code

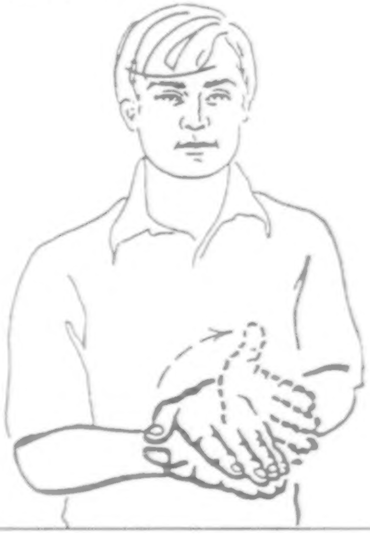
**DOWN** (kinetic)

downward (opposite of up)



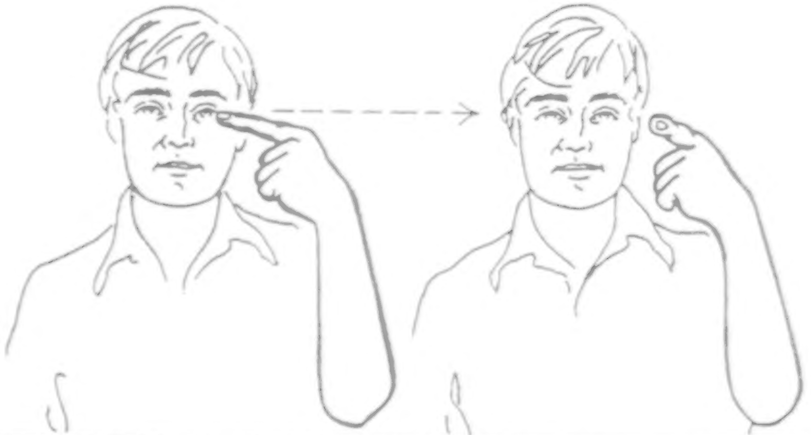
**OPEN** (kinetic)

accessible, coverless, exposed, uncovered



**LOOK** (static)

contemplate, examine, eye, glance, notice, observe, regard, see, view, watch



from: **Amer-Ind Gestural Code Based on Universal American Indian Hand Talk** by M. Skelly, Elsevier Science Publishing Co., Inc. New York, 1982. Used with permission.

LESSON PLAN: 10

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-10 OR DEMONSTRATION:

ASSISTING RESIDENTS WITH HEARING IMPAIRMENTS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define decibels.
2. Define Hertz.
3. List three types of hearing aids.
4. Identify ways in which to care for and operate a hearing aid.
5. Identify communication techniques used with an individual wearing a hearing aid.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Operation of a Hearing Aid
2. TM 2: Types of Hearing Aids

INFORMATIONAL ASSIGNMENT: (Student)

Review information concerning the ear in Unit IV, lesson 4.

REFERENCES: (Instructor's Additional Information)

Bollinger, R.L., et al. *Communication Management of the Geriatric Patient*. Danville: The Interstate Printers and Publishers, Inc., 1977.

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Sanders, D.A. *Aural Rehabilitation*. Englewood Cliffs: Prentice-Hall, Inc., 1971.

Schow, R.L., Christensen, J.M., Hutchinson, J.M., and Nerbonne, M.A. *Communication Disorders of the Aged: A Guide for Health Professionals*. Baltimore: University Park Press, 1978.

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INTRODUCTION:

Hearing impairment in the long-term care resident is of major concern to those healthcare professionals who serve this population. Recent statistics have shown that 13.3% of all persons over age 65 have significant bilateral hearing losses. These data would suggest that knowledge of the hearing process, understanding hearing loss and its causes, familiarity with hearing aid operation, and ability to communicate effectively with the hearing impaired individual will be important skills for rehabilitation and health care specialists. During this lesson we will become familiar with the acoustical terms, types and causes of hearing losses, hearing aids and their operation, as well as basic skills in communicating with the hearing-impaired resident.

LESSON PLAN: 10

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions

    A. Decibels (dB) - measure of sound loudness (II-1)

    B. Hertz (Hz) - measure of sound pitch

    C. Hearing aid - a device for amplifying sound for the hearing-impaired individual. Contains on-off switch, volume control, amplifier, receiver, battery, and ear mold

II. Acoustics

    A. Decibels - a measure of sound intensity; a loud sound would be high in decibels, a quiet sound would be low in decibels

    Example: Conversational speech is about 65 dB.

    B. Hertz - a measure of the frequency or pitch of sound; a high pitched sound would be high in Hertz, a low pitched sound would be low in Hertz

    Example: Conversational speech is generally between 500-2,000 Hz.

III. Hearing Aids

    A. Basic components (TM 1) (II-2)

        1. The switch

            a. "O" - off

            b. "M" - microphone (on); picks up sound

            c. "T" - telecoil switch to be used when using the telephone

        2. Volume control dial

        3. The amplifier - makes the sound louder

        4. The battery - supplies power

        5. The receiver - sends sound to ear

        6. The earmold - plastic piece that fits into the ear

B. Types of hearing aids (TM 2) (II-3)

1. In-the-ear
2. Behind-the-ear
3. Body aid
4. Eyeglasses aid

C. Care of the hearing aid (II-4)

1. Keep the aid dry and away from heat.
2. Clean earmold with warm soapy water and pipe cleaners. NEVER use boiling water or alcohol.
3. Remove aid to shower or swim.
4. Don't twist or bend the plastic tubing.
5. Store extra batteries in a cool, dry place.
6. Don't throw used batteries into a fire--they will explode.
7. It's a good idea to open the battery compartment when the aid is removed to avoid running down the battery.
8. Corrosion may be cleaned from a battery with a pencil eraser.

D. Trouble-shooting when aid is not working properly; check the following: (II-5)

1. Is battery inserted correctly?
2. Is corrosion cleaned off the battery?
3. Is the battery run down?
4. Is cord or tubing defective?
5. Are the ends of the cords or tube connected properly?
6. Is the aid turned on with the volume up?
7. Is the earmold plugged with wax?
8. If the answer to all the above is "no" then the aid must be sent for repair. Never try to repair an aid yourself.

E. Helping the hearing-impaired resident wearing a hearing aid make maximum use of his/her hearing (II-6)

1. Give important instructions in a quiet environment.
2. Get the resident's attention before speaking.
3. Bright lights should be behind the resident so he/she will not be facing a glare.
4. Don't shout at the resident--speak slowly and clearly without exaggeration.
5. Avoid chewing gum or hiding your mouth while talking.
6. Don't call to resident from another room; try to stay 3 to 6 feet from the resident.
7. Watch for signs that the resident is not understanding you. Then repeat or rephrase if necessary.
8. Above all be patient! Avoid showing annoyance or disgust.

IV. Summary and Conclusion

A. Terminology

B. Acoustics

C. Hearing aids

In this lesson we have discussed the importance of knowing about normal hearing and hearing aids. As a restorative nurse assistant you should be aware of the hearing abilities of residents in your care, and be able to assist them with proper operation and care of their hearing aids. In addition, knowing how to communicate effectively with the hearing-impaired resident will be extremely important to the success of her/his rehabilitation program.

LESSON PLAN: 10

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What do we mean by the terms decibels and Hertz?
2. How does a hearing aid work?
3. What are some different types of hearing aids that you are familiar with?
4. What might cause a hearing aid to stop working?
5. How do you clean a hearing aid?
6. What are some key points in communicating with a hearing impaired individual wearing a hearing aid?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES

1. If available, have samples of the various types of hearing aids that students can handle. Have them point out the various parts and practice trouble-shooting as discussed in class.

LESSON PLAN: 10

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

1. Define decibels.

2. Define Hertz.

3. List three types of hearing aids.

   a.

   b.

   c.

For each of the following, write "T" if the statement is true, or "F" if it is false.

___ 4. When a hearing aid is on M it is on.

___ 5. Dead batteries may be thrown in the fireplace.

___ 6. Always clean hearing aids with alcohol to avoid infection.

___ 7. A hearing aid should be removed before a shower.

___ 8. Batteries should be stored in the bathroom medicine cabinet.

___ 9. A hearing aid that is not working may have a corroded battery.

___ 10. Hearing aids may be fixed easily with a small screwdriver.

___ 11. A hearing aid may be dried effectively with a hair dryer.

___ 12. When speaking to a hearing-impaired individual you should speak very slowly and exaggerate your words.

___ 13. Try to stay no more than three to six feet from a hearing impaired resident when speaking to him/her.

___ 14. Shouting at a resident who is wearing a hearing aid will be helpful.

___ 15. When communicating with a resident who is wearing a hearing aid, it is best to talk in a quiet environment.

LESSON PLAN: 10

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1. A measure of sound intensity
2. A measure of sound pitch
3. Any three of the following:
   a. In-the-ear hearing aid
   b. Behind-the-ear hearing aid
   c. Eyeglasses hearing aid
   d. Body aid
4. T
5. F
6. F
7. T
8. F
9. T
10. F
11. F
12. F
13. T
14. F
15. T

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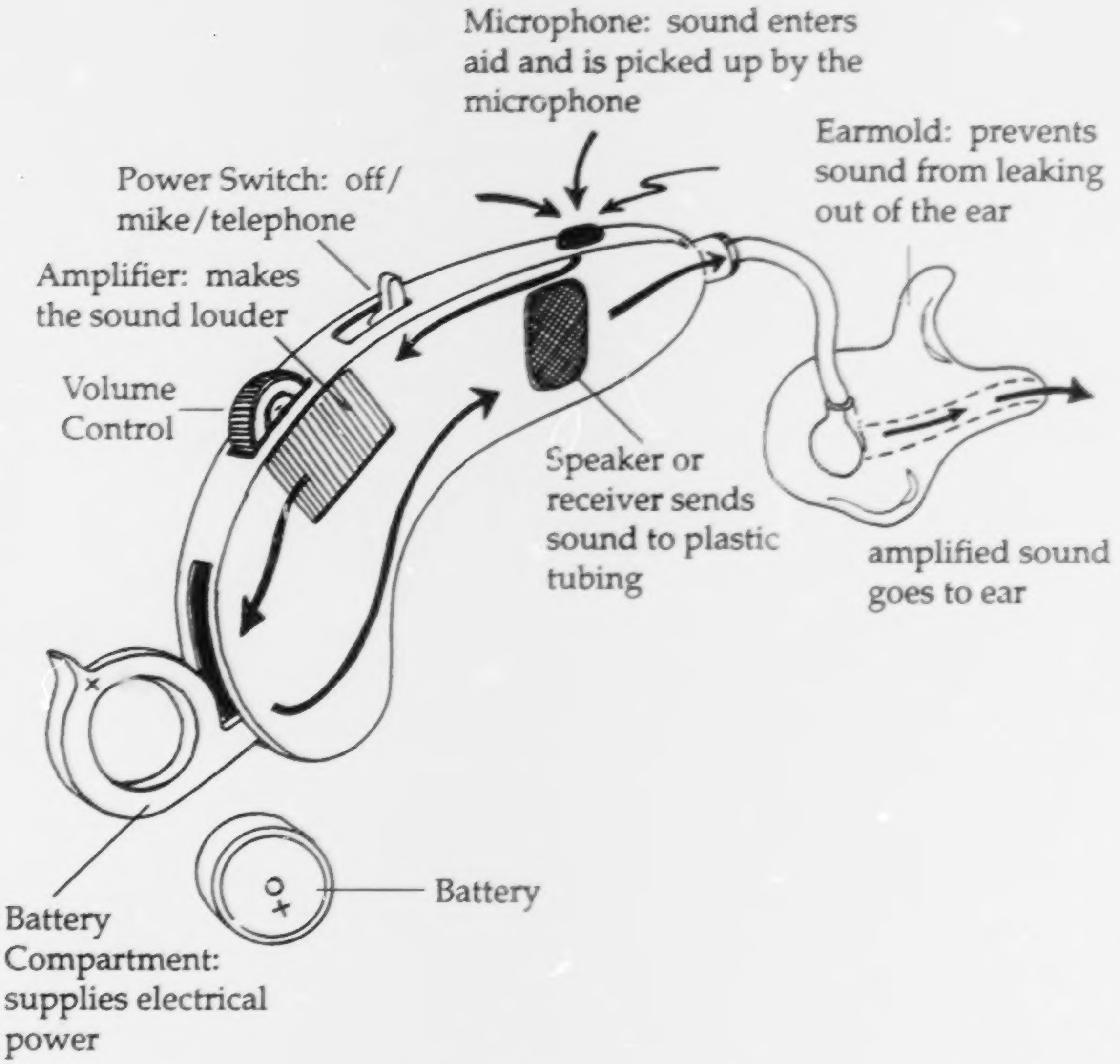
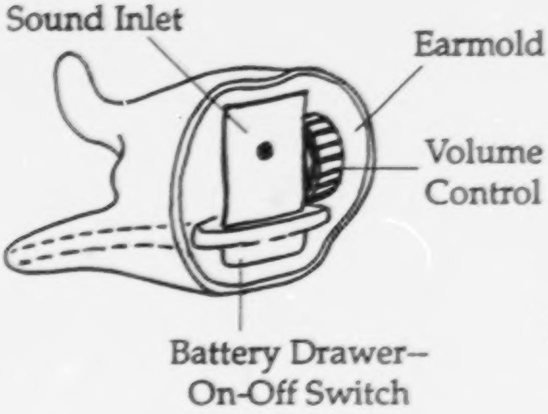
# Operation of a Hearing Aid


Microphone: sound enters aid and is picked up by the microphone
Earmold: prevents sound from leaking out of the ear
Power Switch: off/ mike/telephone
Amplifier: makes the sound louder
Volume Control
Speaker or receiver sends sound to plastic tubing
amplified sound goes to ear
Battery
Battery Compartment: supplies electrical power

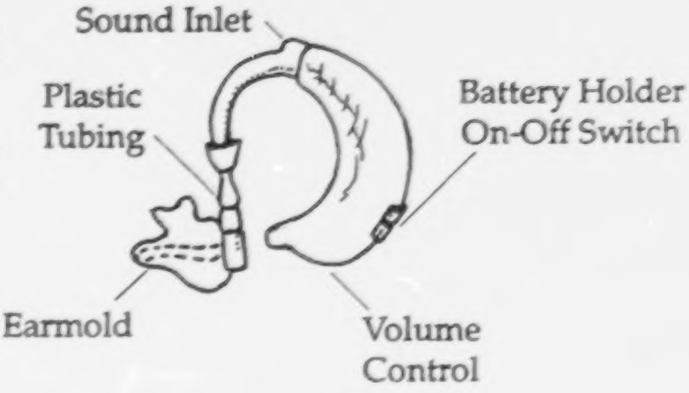
# Types of Hearing Aids

TM 2

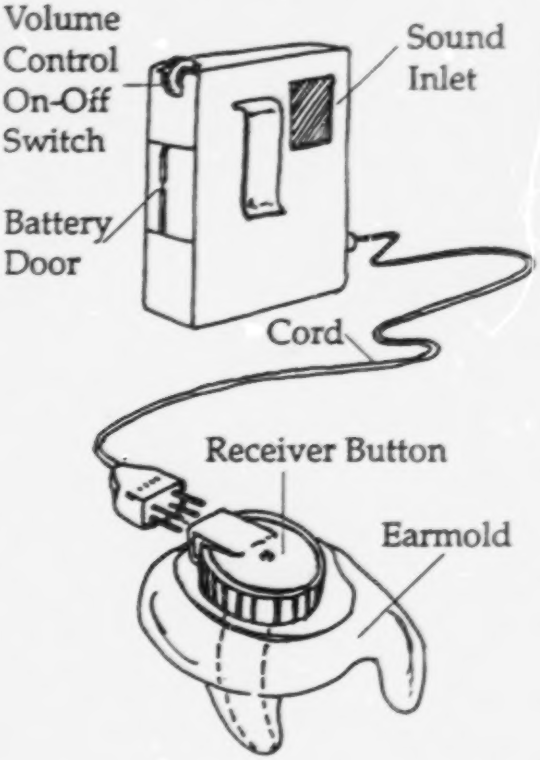
## In the Ear


Sound Inlet
Earmold
Volume Control
Battery Drawer–On-Off Switch

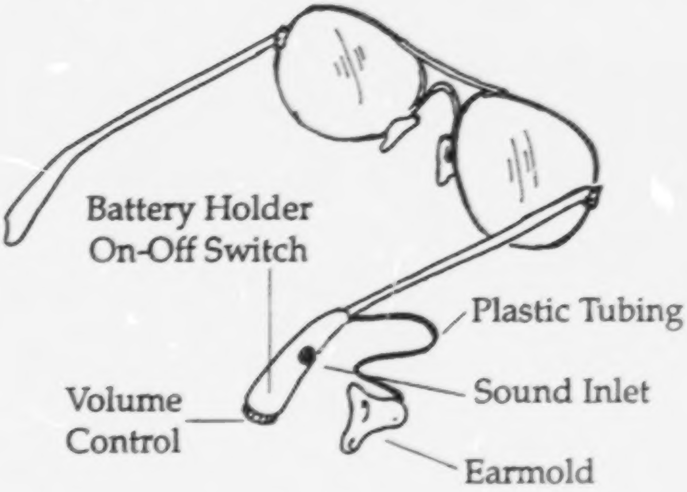
## Behind the Ear


Sound Inlet
Plastic Tubing
Battery Holder On-Off Switch
Earmold
Volume Control

## Body Aid


Volume Control On-Off Switch
Sound Inlet
Battery Door
Cord
Receiver Button
Earmold

## Eyeglasses Aid


Battery Holder On-Off Switch
Plastic Tubing
Sound Inlet
Volume Control
Earmold

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-11 AND DEMONSTRATION: VII-11

## EXERCISE EQUIPMENT AND PROCEDURES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List two principles of assisting with exercise procedures.
3. Identify physiological aims of PROM, AAROM, AROM, and PROM exercises.
4. Identify exercise equipment used in the LTC facility.
5. Identify types of specific exercise techniques or programs.
6. Demonstrate specific range of motion exercises.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Mats
2. TM 2: Weights
3. HO 1: Exercise Equipment
4. HO 2: Range of Motion Exercises
5. Bed or mat and linens
6. Various types of exercise equipment including weights, wall pulleys

INFORMATIONAL ASSIGNMENT: (Student)

Refer to Unit IV, Lesson 2, section III of this manual prior to class and be prepared to discuss it.

REFERENCES: (Instructor's Additional Information)

Dorland's Pocket Medical Dictionary. 24th ed. Philadelphia, PA: W.B. Saunders Company, 1989.

Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, 1987.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, rev. 1987.

INTRODUCTION:

You are familiar (from your CNA classes) with the term ROM. In this lesson, we will further explore the different kinds of ROM exercises, and look at some exercise equipment you may come in contact with and use. In addition we will touch on a few of the many specific exercise programs or techniques you may encounter.

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions

A. Active range of motion (AROM) - resident performs entire movement throughout patterns without assistance

B. Active-assistive range of motion (AAROM) - same ROM patterns except the resident assists in the movement of the body part; requires support

C. Exercise - the performance of physical exertion for improvement of health or the correction of physical deformity due to illness/injury

D. Passive range of motion (PROM) - complete movement of the body part through ROM without assistance from the resident

E. Resistive range of motion (RROM) - resident performs entire movement without assistance and with resistance from external forces (i.e., weights)

II. Principles for Assisting with Exercise Procedures

A. Know ROM patterns [illegible] extremities, neck, and trunk (PROM, AAROM, AROM, and RROM)

B. When assisting resident on a maintenance or restorative program: (II-1)

1. Follow directions of the therapist or nurse explicitly.

2. Never increase the amount of weight or change programs. That is the responsibility of the therapist.

3. Observe resident throughout for signs of pain or discomfort.

4. If resident complains of pain, discontinue program and notify therapist.

5. Encourage resident to relax and do as much of the work as she/he can without assistance; however be ready to provide support as needed.

6. For all ROM exercises, move body part until you feel resistance and no further.

C. If resident cannot complete full pattern (i.e., full hip flexion) in normal planes, never force or stretch the muscle; notify therapist or nurse.

D. Observe the resident for signs of fatigue, changes in health, or improvement; report observations to your supervisor.

III. Primary Physiological Aims of Exercise in Normal Planes (II-2)

A. PROM

1. Maintain functional ROM (joint mobility)
2. Prevent contractures
3. Maintain or improve circulation
4. Maintain proprioception

B. AAROM

1. Maintain or improve functional ROM
2. Provide strengthening to muscles which are impaired
3. Maintain muscle tone
4. Maintain proprioception

C. AROM

1. Maintain or increase muscle strength
2. Increase muscle flexibility
3. Promote coordination
4. Prevent contractures

D. RROM (II-3)

1. Increase muscle strength
2. Increase muscle or general endurance

IV. Exercise Equipment in the LTC Facility (HO 1) (II-4)

A. Mats (TM 1)

1. May be placed on the floor; however usually on an elevated platform
2. Uses:

        a. ROM exercise

        b. Rolling - retraining and increasing strength and endurance of trunk muscles

        c. Sitting - exercises for sitting balance and strengthening

        d. Coordination

B. Weights (TM 2)

    1. Types

        a. Sand bags - various weight (i.e., 1 lb., 5 lb., 10 lb.)

            1) Wrap around vinyl with Velcro™ closure

            2) Canvas with straps

        b. Barbells or free weights

        c. Wall pulleys (resistive) - used with many residents, but especially useful for residents who are wheelchair bound

        d. Over the mat pulleys (active-assistive)

    2. Uses:

        a. Sand bags and barbells are easily transported to resident rooms if necessary for upper extremity (UE) and lower extremity (LE) exercises.

        b. Increase muscle strength through increasing weight and repetitions

        c. Increase muscle endurance through light weight with more repetitions

C. Shoulder wheel - active-assistive and resistive

D. Stationary bicycle or restorator (pedals with crossbar mounted on a chair)

    1. Increase endurance

    2. Improve coordination

    3. When mechanical resistance is applied, it increases strength.

E. Parallel bars - can be utilized for general coordination and balance exercises to provide a support or handrest as needed in addition to use for ambulation

V. Specific Techniques or Programs of Exercise

A. Developed for each resident by a licensed therapist

B. Could include:

1. Isometric exercise

a. Muscle contracts without movement of body parts

b. Can be utilized following surgery to maintain muscle tone and strength while awaiting approval from orthopedic surgeon to begin movement (i.e., hip, knee, shoulder)

c. Can be used to increase muscle tone and strength when painful or degenerating arthritic joints should not be moved throughout ROM

2. PNF patterning - proprioceptive neuromuscular facilitation

a. Group of UE and LE exercises used to help facilitate the reestablishment of nerve and muscle pathways

b. Can be initially active-assistive and progress to resistive with instruction of therapist and improvement of nerve to muscle supply or establishment of pathway

c. Utilizes diagonal patterns across body, rather than normal planes

3. Wand exercises

a. Use of cane or short broomstick (wand)

b. Can be used for UE strengthening of injured or weak arm

c. Both hands grasp "wand" and good arm assists injured throughout ROM.

C. RNA would only assist resident who has completed skilled therapy and is at a maintenance level.

## VI. Steps of Procedure for Range of Motion Exercises in Normal Planes

A. Steps beginning procedure

1. Wash your hands.
2. Identify and greet resident. Identify self.
3. Explain what you are going to do.
4. Provide privacy - make sure resident is wearing adequate clothing.
5. Raise bed to a comfortable working height.
6. Assist resident into supine position.
7. **CAUTION: For all ROM exercises, move body part until you feel resistance AND NO FURTHER.**

B. Procedure for range of motion exercises (HO 2).

1. Neck
    a. Flexion/extension
        1) Supporting head with hands, bend head forward trying to touch the chest with the chin.
        2) Bring head back to pillow.
    b. Right and left rotation - turn head from side to side.
    c. Right and left lateral flexion - tilt head so that the ear is moved toward the shoulder.
2. Shoulders
    a. Flexion/extension
        1) Supporting the arm at the wrist and elbow, lift the arm toward the ceiling, continue lifting over the resident's head.
        2) Slowly lower the arm to the resident's side.
    b. Abduction/adduction
        1) Supporting the arm at the elbow and shoulder, move the arm out to the side, continue moving toward resident's head.

        2) Slowly move the arm back toward the center of body.

    c. Internal/external rotation

        1) Move the arm away from the body to shoulder level with the elbow bent at a 90° angle.

        2) Bring the hand forward to touch the bed and then backward to touch the bed.

3. Elbow

    a. Flexion/extension

        1) Bend the arm at the elbow and touch the shoulder then straighten the arm.

        2) Bend the arm at the elbow and touch the chin then straighten the arm.

    b. Pronation/supination

        1) Grasp the resident's forearm just above the wrist; support the arm at the elbow joint.

        2) Turn palm of the hand toward floor and then away from the floor.

4. Wrist

    a. Flexion/extension - support arm and hand; bend the wrist forward, straighten, and then bend wrist backward.

    b. Abduction/adduction - move the hand from side to side at the wrist.

5. Fingers

    a. Flexion/extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct resident to make a clenched fist and then relax it.

    b. Abduction/adduction - move each finger away from the nearest finger and then return it.

    c. Thumb opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.

   d. Thumb rotation - move the thumb in a circle one direction and then the other direction.

6. Hip and knee

   a. Flexion/extension

      1) Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.

      2) Bend the knee and move toward the chest, slowly straighten the knee.

   b. Abduction/adduction

      1) Move the leg straight out to the side of the body.

      2) Slowly move the leg back toward the center of the body.

   c. Internal/external rotation - support the knee and ankle joints with the hip and knee bent; move the ankle in toward the opposite leg and then outward.

7. Ankle

   a. Inversion/eversion - supporting the foot at the ankle joint, turn the foot toward the opposite foot and then away from the opposite foot.

   b. Dorsiflexion/plantarflexion - point the foot up toward the knee, then point downward.

8. Toes

   a. Flexion/extension - bend and then straighten the toes.

   b. Abduction/adduction - move each toe toward the next toe and then away from the next toe.

C. Steps ending procedure

1. Lower bed to a position of safety; raise side rails where ordered.

2. Make the resident comfortable; place call signal within reach.

3. Wash your hands.

## VII. Summary and Conclusion

A. Terms and definitions

B. Principles for assisting with exercise procedures

C. Primary physiological aims of exercise in normal planes

D. Exercise equipment in the LTC facility

E. Specific techniques/programs of exercise

F. Steps of procedure for range of motion exercise in normal planes

Therapy consultants receive extensive training in evaluating residents and developing exercise programs specific to each resident. In this lesson you have learned about some of the exercise equipment you may encounter in a LTC facility and the principles you will be expected to use when working with residents. The three specific exercise techniques presented are but a sampling of the many programs or techniques you will probably be exposed to. Through the learning about the physiological aims of the different kinds of ROM exercise, you can understand what an important role you play in assisting the resident to meet his/her goals.

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. Which of the principles of performing exercise procedures do you feel is the most important and why?

2. Why is it important for the RNA to be able to demonstrate the different kinds of ROM without any use of equipment?

3. What differentiates PROM from AAROM? AROM from PROM?

4. What different kinds of exercise equipment have you been exposed to in your work as a CNA?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Arrange a field trip to a physical therapy department and an occupational therapy department and examine the various types of exercise equipment.

    a. Ask therapists to demonstrate the use of equipment.

    b. Have therapists explain what types of residents might use each kind.

2. Follow HO 2 with the class. Have each student demonstrate on you, the difference between PROM, AAROM, RROM, and AROM without the use of equipment.

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

Match the following terms to the correct definitions by writing the appropriate letter in the blank.

____ 1. Resident performs entire movement without assistance and with resistance from external forces

____ 2. The performance of physical exertion for improvement of health or the correction of physical deformity due to illness/injury

____ 3. Same ROM patterns except the resident assists in the movement of the body part; requires support

____ 4. Complete movement of the body part through ROM without assistance from the resident

____ 5. Resident performs entire movement throughout patterns without assistance

a. Exercise

b. Passive range of motion (PROM)

c. Active-assistive range of motion (AAROM)

d. Active range of motion (AROM)

e. Resistive range of motion (RROM)

6. List two principles the RNA should follow when assisting with exercise procedures.

a.

b.

Match the following ROM exercises to the intended purpose by writing the appropriate letter in the blank.

____ 7. Maintain or increase muscle strength; increase muscle flexibility; promote coordination; prevent contractures

____ 8. Maintain functional ROM; prevent contractures; maintain or improve circulation; maintain muscle tone; maintain proprioception

____ 9. Increase muscle strength; increase muscle or general endurance

____ 10. Maintain or improve functional ROM; provide strengthening to impaired muscles; maintain muscle tone; maintain proprioception

a. PROM

b. AAROM

c. AROM

d. RROM

Match the following specific techniques or programs to the correct descriptions by writing the appropriate letter in the blank.

____ 11. Group of UE and LE exercises used to help facilitate the reestablishment of nerve and muscle pathways utilizing diagonal patterns across body rather than normal planes

____ 12. Uses cane or short broomstick; can be used for UE strengthening of injured or weak arm; good arm assists injured arm throughout ROM

____ 13. Muscle contracts without movement of body part; can be utlized following surgery to maintain muscle tone and strength while waiting to begin movement; can be used to increase muscle tone and strength for arthritic joints which should not be moved throughout ROM

a. Isometric exercise

b. PNF patterning

c. Wand exercises

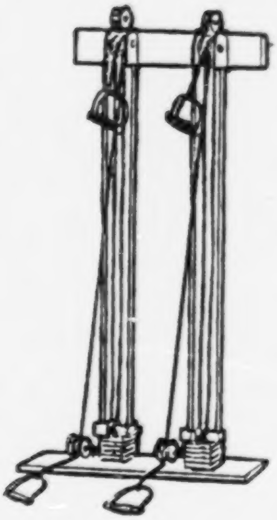
Match the equipment description to the appropriate picture by placing the correct letter in each blank.

____ 14. Used to learn rolling

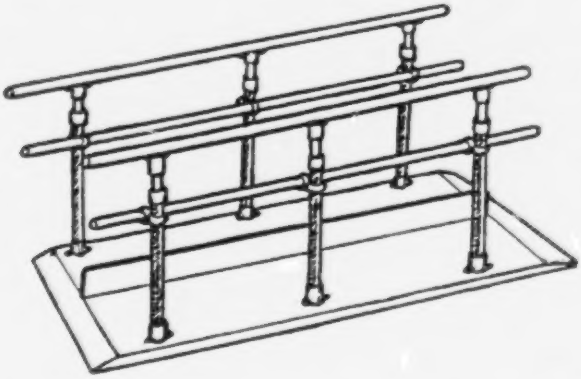
____ 15. Easily transported to resident rooms for arm and leg exercises

____ 16. Especially useful form of active-assistive exercise for residents who are wheelchair bound

____ 17. Can be used for general coordination and balance exercises to provide a support as needed



a.



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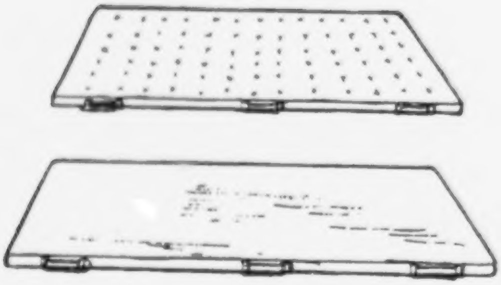
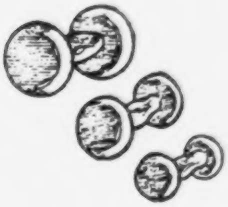


c.



d.

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS: NAME OF STUDENT:____________________

## SPECIFIC RANGE OF MOTION EXERCISES IN NORMAL PLANES

Equipment: 1. Hospital bed made up with linens

| DID THE STUDENT | YES | NO |
|---|---|---|
| Steps Beginning Procedure<br>1. Wash hands. | | |
| 2. Identify and greet resident. Identify self. | | |
| 3. Explain what he/she is going to do. | | |
| 4. Provide privacy--make sure resident is wearing adequate clothing. | | |
| 5. Raise bed to a comfortable working height. | | |
| 6. Assist resident into supine position. | | |
| Procedures for Range of Motion Exercises<br>Neck: Flexion/Extension<br>1. Supporting head with hands, bend head forward trying to touch the chest with the chin. | | |
| 2. Bring head back to pillow. | | |
| Neck: Right and Left Rotation<br>Turn head from side to side. | | |
| Neck: Right and Left Lateral Flexion<br>Tilt head so that the ear is moved toward the shoulder. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| Shoulders: Flexion/Extension<br>1. Supporting the arm at the wrist and elbow, lift the arm toward the ceiling, continue lifting over the resident's head until resistance is felt. | | |
| 2. Slowly lower the arm to the resident's side. | | |
| Shoulders: Abduction/Adduction<br>1. Supporting the arm at the elbow and shoulder, move the arm out to the side, continue moving toward resident's head. | | |
| 2. Slowly move the arm back toward the center of body. | | |
| Shoulders: Internal/External Rotation<br>1. Move the arm away from the body to shoulder level with the elbow bent at a 90° angle. | | |
| 2. Bring the hand forward to touch the bed and then backward to touch the bed. | | |
| Elbow: Flexion/Extension<br>1. Bend the arm at the elbow and touch the shoulder then straighten the arm. | | |
| 2. Bend the arm at the elbow and touch the chin then straighten the arm. | | |
| Elbow: Pronation/Supination<br>1. Grasp the resident's forearm just above the wrist; support the arm at the elbow joint. | | |
| 2. Turn palm of the hand toward floor then away from the floor. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| Wrist: Flexion/Extension<br>Support arm and hand; bend the wrist forward, straighten, and then bend it backward. | | |
| Wrist: Abduction/Adduction<br>Move the hand from side to side at the wrist. | | |
| Fingers: Flexion/Extension<br>Support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct resident to make a clenched fist and then relax it. | | |
| Fingers: Abduction/Adduction<br>Move each finger away from the nearest finger and then return it. | | |
| Fingers: Thumb Opposition<br>Bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back. | | |
| Fingers: Thumb Rotation<br>Move the thumb in a circle one direction and then the other direction. | | |
| Hip and Knee: Flexion/Extension<br>1. Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg. | | |
| 2. Bend the knee and move toward the chest, slowly straighten the knee. | | |
| Hip and Knee: Abduction/Adduction<br>1. Move the leg straight out to the side of the body. | | |
| 2. Slowly move the leg back toward the center of the body. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| Hip and Knee: Internal/External Rotation<br>Support the knee and ankle joints with the hip and knee bent; move the ankle in toward the opposite leg and then outward. | | |
| Ankle: Inversion/Eversion<br>Supporting the foot at the ankle joint, turn the foot toward the opposite foot and then away from the opposite foot. | | |
| Ankle: Dorsiflexion/Plantarflexion<br>Point the foot up toward the knee, then point downward. | | |
| Toes: Flexion/Extension<br>Bend and then straighten the toes. | | |
| Toes: Abduction/Adduction<br>Move each toe toward the next toe and then away from the next toe. | | |
| Steps Ending Procedure<br>1. Lower bed to a position of safety; raise side rails and where ordered. | | |
| 2. Make the resident comfortable; place call signal within reach. | | |
| 3. Wash hands. | | |

The student has satisfactorily completed the procedure "SPECIFIC RANGE OF MOTION EXERCISES IN NORMAL PLANES" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 11

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

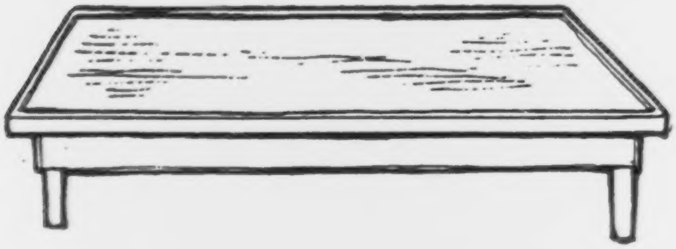
ANSWERS TO EVALUATION ITEMS:

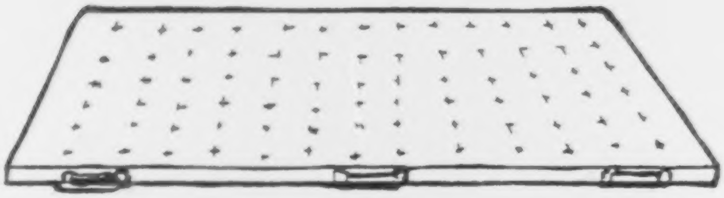
1. e
2. a
3. c
4. b
5. d
6. The student may list any two of the following:
   a. Know ROM patterns for extremities, neck, and trunk (PROM, AAROM, AROM, and RROM)
   b. When assisting resident on a maintenance or restorative program:
      1. Follow directions of the therapist explicitly.
      2. Never increase the amount of weight or change programs. That is the responsibility of the therapist.
      3. Observe resident throughout for signs of pain or discomfort.
      4. If resident complains of pain, discontinue program and notify therapist.
      5. Encourage resident to relax and do as much of the work as she/he can without assistance; however be ready to provide support as needed.
      6. For all ROM exercises, move body part until you feel resistance and no further.
   c. If resident cannot complete full pattern (i.e., full hip flexion) in normal planes, never force or stretch the muscle; notify therapist
   d. Observe the resident for signs of fatigue, changes in health, or improvement; report observations to your supervisor
7. b.
8. a
9. d
10. c
11. b
12. c
13. a
14. c
15. d
16. a
17. b

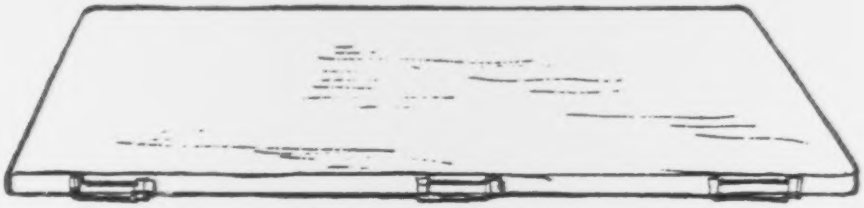
TM 1

# Mats

## Plain and Platform

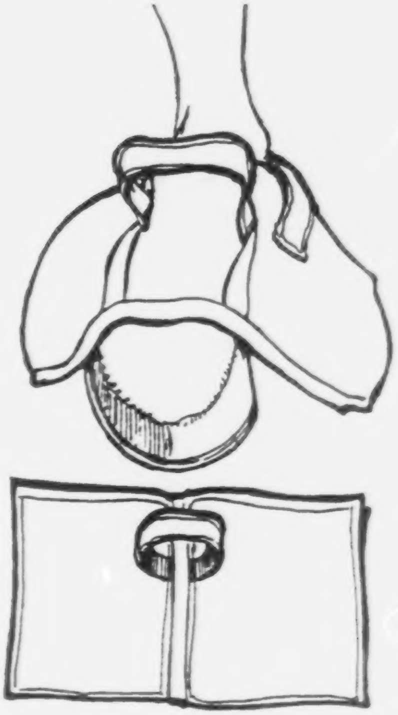




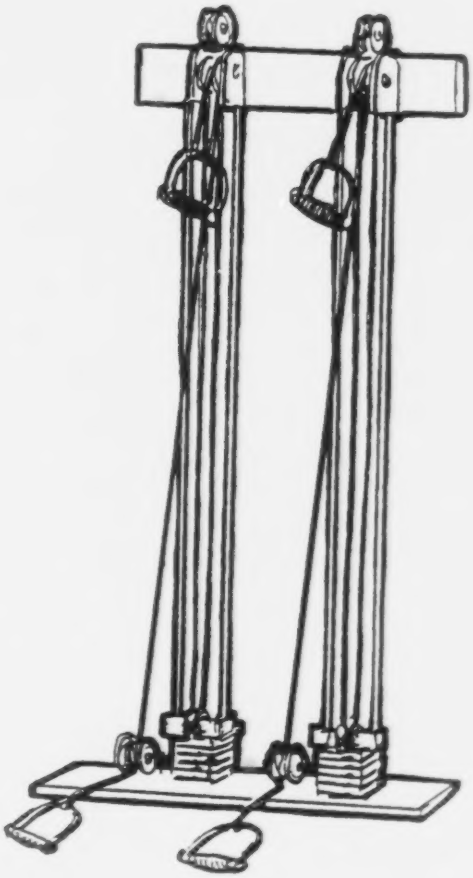


# Weights

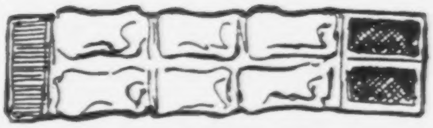
TM 2



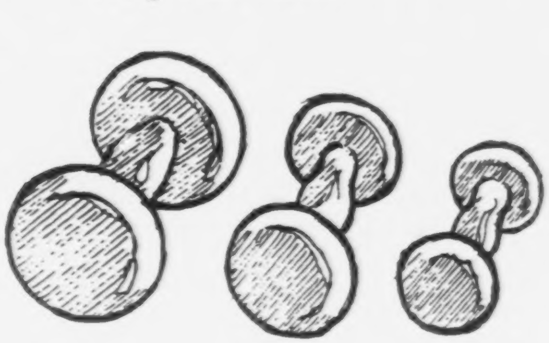
Sand Bags



Pulleys

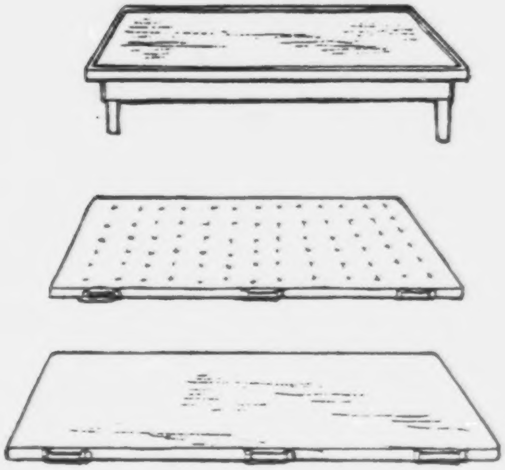


Wrap Around



Bar Bells

# Exercise Equipment

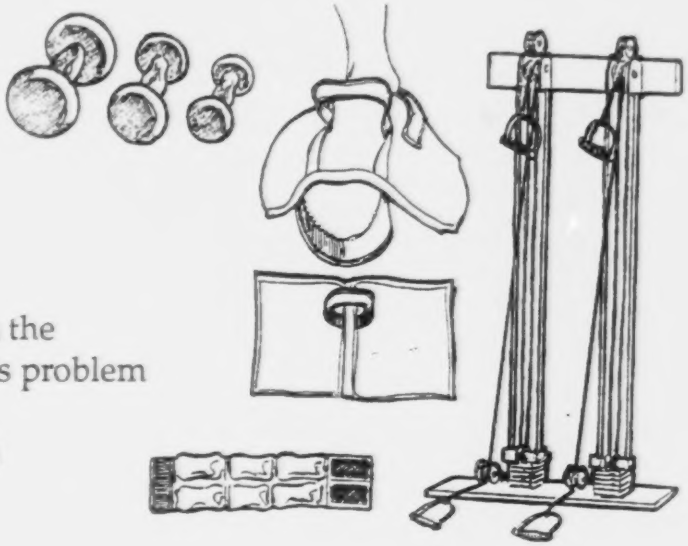


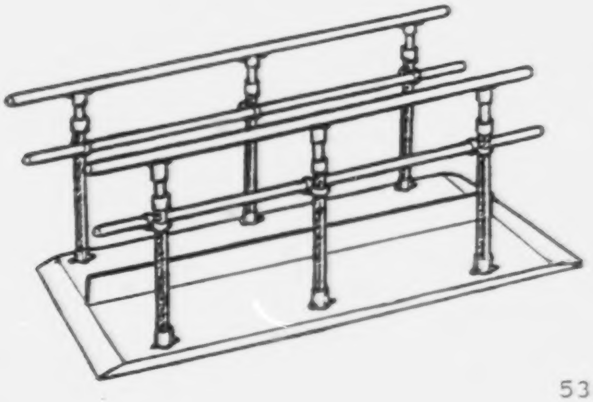
**MATS**

- May be placed on the floor or be on an elevated platform
- Used for exercise, rolling, sitting, and coordination

**WEIGHTS**

- Different types
  - -Barbells
  - -Sandbags
  - -Wall pulleys
  - -Over-the-mat pulleys
- Type used depends upon the resident and the resident's problem
- Used to increase strength



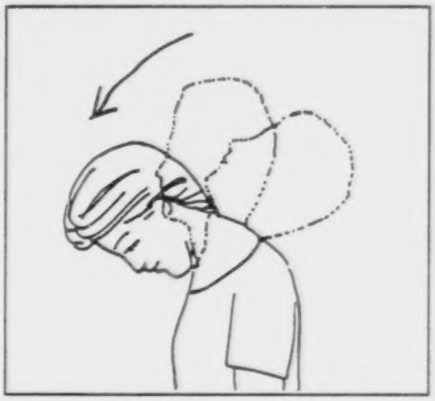


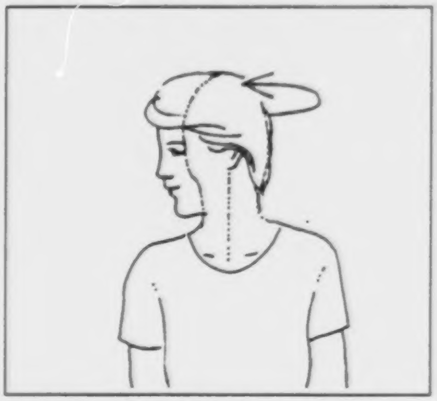
**PARALLEL BARS**

- Can be utilized for coordination and balance exercises to provide a support or handrest as needed
- Therapist stands inside the bars with the resident

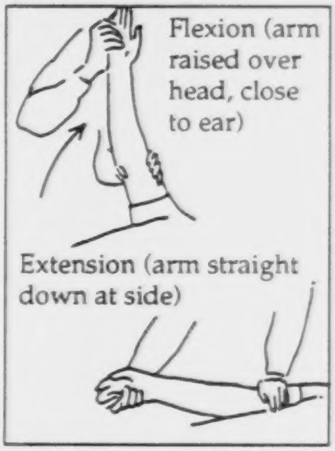
# Range of Motion Exercises

## NECK


Flexion/Extension

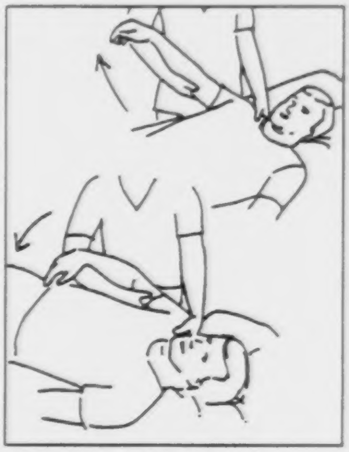

Right and Left Rotation

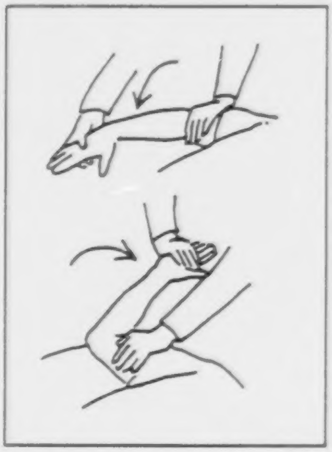
## SHOULDERS


Flexion (arm raised over head, close to ear)

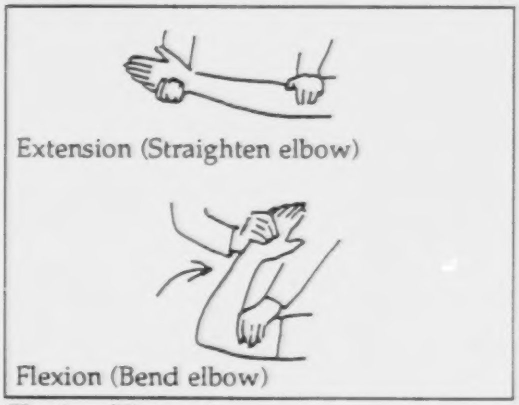
Extension (arm straight down at side)

Flexion/Extension


Abduction/Adduction

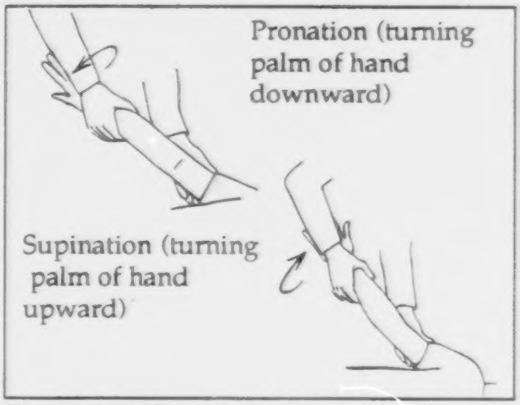

Internal/External Rotation

## ELBOW


Extension (Straighten elbow)

Flexion (Bend elbow)

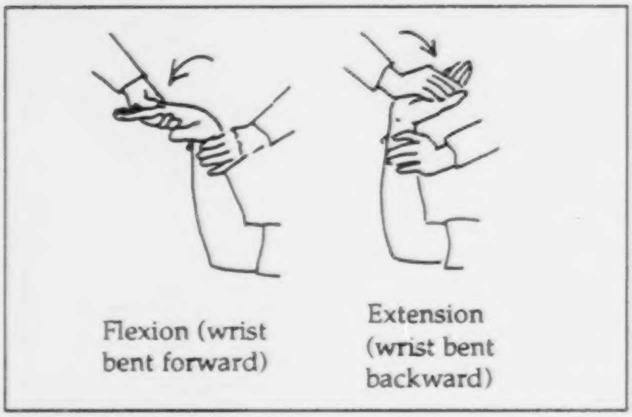
Flexion/Extension


Pronation (turning palm of hand downward)

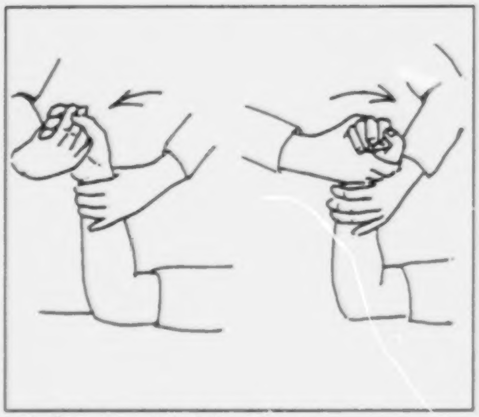
Supination (turning palm of hand upward)

Pronation/Supination

## WRIST

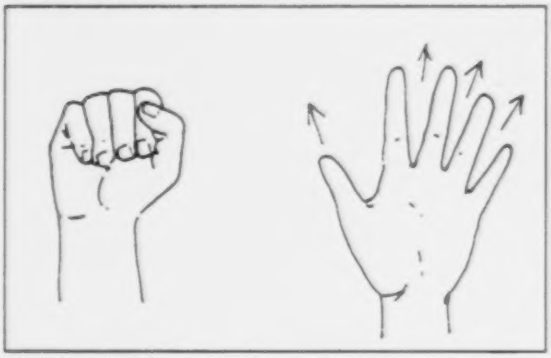

Flexion (wrist bent forward)
Extension (wrist bent backward)

Flexion/Extension

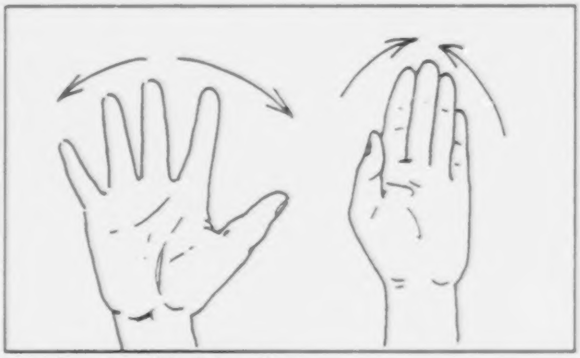


Abduction/Adduction

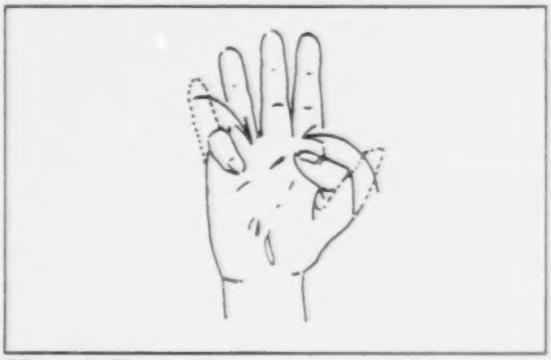
## FINGERS



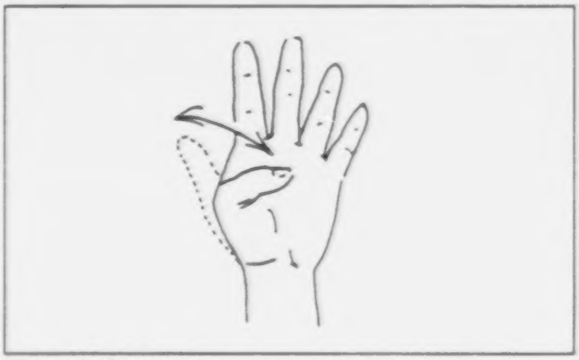
Flexion/Extension



Abduction/Adduction

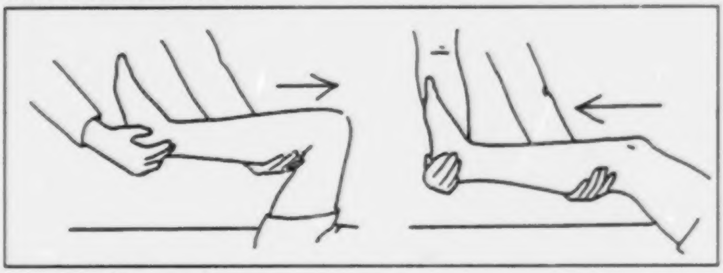


Thumb Opposition

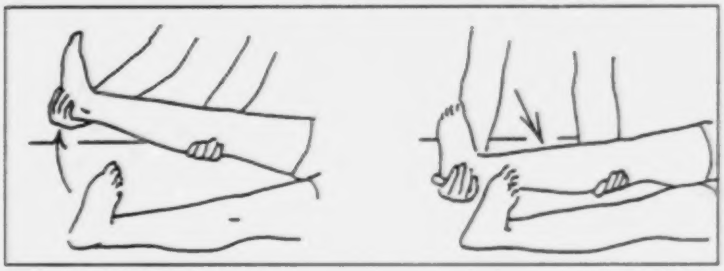


Thumb Rotation

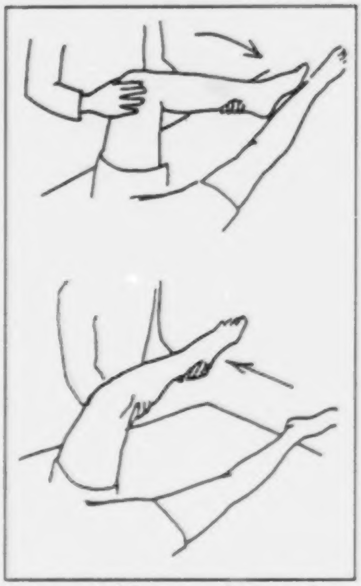
## HIPS AND KNEE



Flexion/Extension

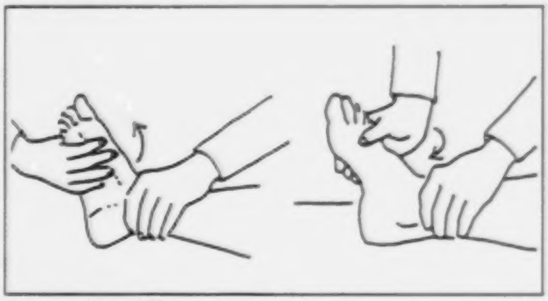


Abduction/Adduction

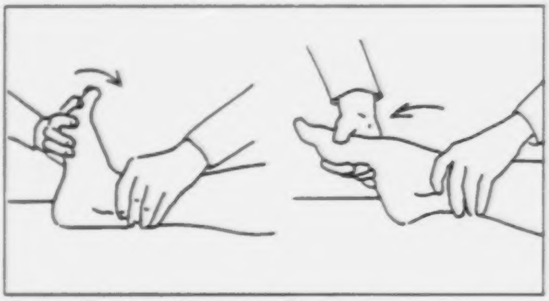


Internal/External Rotation

## ANKLE

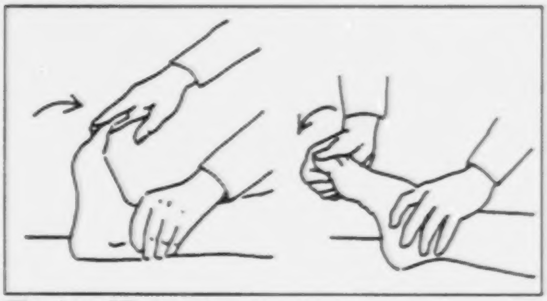


Inversion/Eversion

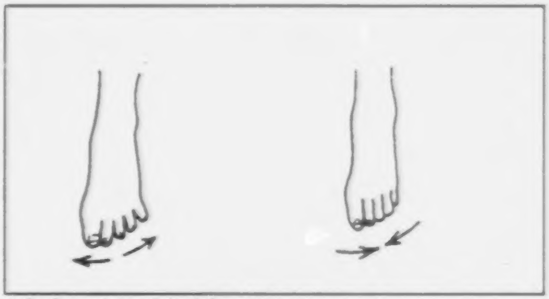


Dorsiflexion/Plantarflexion

## TOES



Flexion/Extension



Abduction/Adduction

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-12 AND DEMONSTRATION: VII-12

## TRANSFER TECHNIQUES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. State the two determinants for transferring a resident.
3. Differentiate between the types of transfers.
4. List five hints in transfer.
5. Demonstrate specific transfer techniques.
    a. Two-person lift (passive transfer)
    b. Two-person lift for resident with shoulder problem
    c. Dependent standing pivot transfer (passive transfer)
    d. Active or assisted standing pivot transfer
    e. Transfer of resident to a car (dependent, assisted, or active).

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Determinants for Transfer
2. TM 2: Passive (Dependent) Transfer
3. TM 3: Active (Assisted or Independent) Transfer
4. HO 1: Hints in Transfer
5. Transfer belts for each student's use

6. Various surfaces (i.e., bed, mat, car)
7. Various chairs (i.e., wheelchair, geri-chair, straight-back chair)

INFORMATIONAL ASSIGNMENT:

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987. Review Unit VII, Lesson 49, "Transfer Activities."

REFERENCES: (Instructor's Additional Information)

Minor, Mary Alice Duesterhaus and Scott Duesterhaus Minor. Patient Care Skills. 2nd ed. Reston VA: Reston Publishing Co., Inc., 1990 .

Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, 1987.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

INTRODUCTION:

In your training as a CNA, you were instructed in the importance of safety in lifting and transferring residents. This not only insures your safety, but that of the resident as well. There are some basic points and tips you should know about transferring residents, as well as how to perform the basic transfers. By developing the ability and knowledge necessary to perform efficient transfers, you can, with the help of your consultants, insure the mobility of your residents and thus improve their quality of life.

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Terms and Definitions

A. Contact guarding - resident requires hand contact because of occasional loss of balance (protective safeguard)

B. Independent - resident requires no assistance; performs activity safely alone and feels secure

C. Maximal assist - resident contributes little or nothing toward execution of activity, is totally dependent

D. Minimal assist - resident requires small amount of help to accomplish activity

E. Moderate assist - resident definitely requires help, but contributes half the effort

F. Stand-by assist - resident requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

G. Transfers - methods of moving a resident from one surface to another

H. Unable - resident lacks the necessary strength or mental capability to perform any part of the activity, or performance is impractical

II. Determinants for Transfer (TM 1)

A. Efficiency - the best way with the least amount of help

B. Safety - the safest transfer for the resident and the RNA (II-1)

**NOTE: It is best to always use transfer belt; enables the RNA to have a "handle" on resident.**

III. Types of Transfers

A. Passive (dependent) (TM 2) (II-2)

1. No help or very little help from the resident

2. RNA performs nearly all of the transfer.

B. Active (assisted or independent) (TM 3)

1. The resident performs a considerable amount of the transfer with assistance.

2. The resident performs the transfer alone or with the RNA standing by.

**NOTE: Residents should never have his/her arms around RNA's neck.**

IV. Hints in Transfer (HO 1) (II-3)

**NOTE: In executing any transfer, whether passive or active, it is extremely important to remember to use a verbal cue system which should be established before beginning the transfer.**

A. Moving toward a stronger side is useful.

B. When standing, the person with one stronger leg usually can transfer better when moving that side of his/her body toward the transfer object.

C. With generalized muscle involvement, a stronger arm may be used as a stabilizer during standing and pivoting and thus may determine the direction.

D. If transfer occurs while sitting with movement toward the side, the resident will move in the direction of his/her stronger arm.

E. Sitting transfers can also be done by moving forward or backward to the object. (Good trunk balance is needed.)

F. Equalize the height of the transfer surface when possible.

G. Support of feet will increase resident's stability during sitting transfers.

H. When standing to transfer, move the head and trunk forward so the center of gravity is brought forward. This helps the resident to stand with minimal effort.

I. Always explain the details of the transfer procedure to the resident prior to transferring.

## V. Steps of Procedure for Transferring Residents

### A. Two-person lift (passive transfer) (II-5)

CAUTION: **This procedure is not to be used on residents with shoulder or upper extremity problems (i.e., hemiplegic with possible shoulder subluxation, history of pathological fractures, or history of shoulder dislocation).**

1. Place the wheelchair parallel to or slightly diagonal to the side of the bed.

2. Lock the brakes of the chair to prevent it from moving during the transfer.

3. If possible, remove the arm of the wheelchair next to the bed to prevent bumping the resident when moving to and from the chair.

4. If possible, swing away or remove the leg rests of the chair to keep them from getting in the way of the person lifting the legs.

5. Slide or assist resident to the edge of bed.

6. The taller person should, ideally, be at the back of the resident, as this lifter will need to lift the resident higher than the lifter at the legs. This person will direct the transfer.

7. The lifter at the back of the chair now assists the resident to a sitting position on the bed. If the resident is very weak, this person may need to hold the resident in the sitting position.

8. The lifter at the back of the chair now places his/her arms under the arms and around the rib cage of the resident. The lifter should grasp the resident's left forearm/wrist with his/her right hand and the resident's right forearm/wrist with his/her left hand.

9. Both lifters widen the base of support by placing feet apart and bending knees and hips.

   NOTE: Do not bend the back.

10. The lifter at the legs places his/her arm that is toward the resident's head, as far under the resident's thighs as possible. The other arm supports the resident's lower legs at or just above the ankles.

NOTE: **This allows more weight of the resident to be lifted by the person at the legs.**

11. Instruct the resident to pull his/her elbows toward his/her ribs as the lift takes place.

    NOTE: **This will stabilize the resident's shoulders for the lift.**

12. The lifter at the back will count to three and give the command to "lift" at which time both lifters straighten their hips and knees, lifting and placing the resident in the chair or on the bed.

    NOTE: **A verbal cue system must be established prior to actually lifting the resident (i.e,. "one, two, three, LIFT.").**

13. Adjust resident's position in the bed or wheelchair as needed.

B. Two-person lift for resident with shoulder problem

1. Repeat steps 1-7 of procedure A.

2. Step 8 - lifter at front puts transfer belt around resident snugly and lifter at back puts his/her arms around resident and under the arms; grasping transfer belt in front.

3. Continue with steps 9-12 of procedure A.

C. Dependent standing pivot transfer (passive transfer)

NOTE: **The dependent standing pivot transfer is generally used for a resident who can bear weight on one or both of the lower extremities but has no voluntary control of the lower extremities and limited use of the upper extremities (i.e., quadriplegic) or is unable to help because of weakness, obesity, mental status changes, etc.**

1. Place a transfer belt around the resident's waist.

    NOTE: **This provides a "handle" for better control of the resident.**

2. Place the wheelchair and resident at a slight angle to the surface to which the resident will be transferred, with the front of the wheelchair closest to the surface; or, place the wheelchair

parallel to the surface to which the resident will be transferred.

3. Lock the brakes of the wheelchair.

4. If possible remove the armrest on the side to which the resident will be transferred.

5. Lift the pedals of the chair; if the leg rests are the swing-away or removable type, swing them out of the way or remove them. Place the resident's feet flat on the floor.

6. Slide the resident forward in the chair using one of the following methods:

   a. Place one arm around one of the resident's shoulders; have the resident lean toward that side (onto your arm) to shift his/her weight off the buttocks on the opposite side. With your other hand assist the resident to move the raised side forward by lifting and pulling forward under the thigh. Reverse your hand position to move the other side forward. Repeat these steps until the resident is sitting on the front edge of the chair.

   b. Hook your arm behind the resident's knees and pull while pushing on the wheelchair seat with your other hand.

   NOTE: **You should get the resident to help scoot himself/herself forward in the chair whenever possible.**

7. Block the resident's feet by placing your feet in a "V" in front of his/her feet.

8. Squat slightly (bend the hips and knees, not the back) and place your knees at the front and slightly outside resident's knee caps (patella).

9. Lean the resident forward and ask him/her to place his/her arms around your shoulders (not your neck).

   NOTE: **The resident's head should be on your shoulder that is opposite the direction of the transfer.**

10. Reach around the resident and grasp the belt in the back (or place your hands under the resident's buttocks).

11. As you count to three and in time with the count, use the backward rocking motion to develop some momentum. On the "LIFT" command lean (rock) back straightening your legs and pull the resident's hips toward you while blocking his/her knees with your knees.

NOTE: **As you rock and lean back, the resident will begin to rise from the chair. With each count, the resident should rise a little higher.**

12. Stand the resident just far enough to clear the wheel of the chair.

13. Pivot the resident while continuing to block his/her knees and feet (to prevent falling).

NOTE: **You must pivot (move) your feet and the resident's feet to prevent twisting your back and potential injury.**

14. Once pivoted, slowly squat and lean back as you lower the resident to the transfer surface.

15. To assist the resident back into the wheelchair, reverse the steps of the procedure.

NOTE: **For the dependent resident for which the dependent standing pivot transfer would be unsafe, it is best to use a mechanical (hydraulic) lift.** (II-6)

D. Active or assisted standing pivot transfer

NOTE: **The active or assisted standing pivot transfer is used with any resident who has some ability to assist in the performance of the transfer. Adjustments are made in the transfer according to the resident's condition and/or restrictions and his/her ability to assist. Residents with one-sided weakness, lower extremity weakness/paralysis, following orthopedic surgery, etc. may be appropriate for this transfer technique.**

Transferring the resident with one-sided weakness:

1. Place a transfer belt around the resident's waist.

NOTE: This provides a "handle" for better control of the resident.

2. Place the wheelchair slightly diagonal to (as previously described) or parallel the side of the bed so the resident is moving toward his/her stronger side (when possible).

3. Lock the brakes on the wheelchair to prevent the chair from rolling as you place the resident in it.

4. The armrests should be left in place to allow for the resident to better assist in the transfer. However, this also requires the resident to come closer to a complete standing position during the transfer.

   NOTE: **If the resident is unable to come close to a complete standing position, remove the arm of the chair next to the bed to prevent the resident from bumping the arm during the transfer and to allow the transfer to be completed without the resident coming to a complete standing position.**

5. Lift the pedals of the chair; if the leg rests are the swing-away or removable type, swing them out of the way or remove them.

6. Have the resident move forward so he/she is sitting on the edge of the chair and so his/her feet are flat on the floor and slightly apart. If the resident cannot move forward independently, you may need to assist him/her.

7. Stand in front of the resident slightly toward the resident's involved side.

8. Block the resident's involved foot and knee with your feet and knees. If you are familiar with the resident's abilities, you may be able to block the involved foot and knee with your foot and knee nearest the wheelchair.

   NOTE: **Spread your feet slightly (be careful if using both of your feet to block the resident's foot to increase your base of support and, if needed, bend at the hips and knees, not the back.**

9. Place your arms around the resident under the uninvolved arm and over the involved arm if the resident is not able to use it (this protects the arm from hitting anything during the transfer). Grasp the belt in back.

10. Have the resident place his/her uninvolved hand on the bed next to his/her hip.

11. Count to three and say "lift." On "lift, have the resident lean forward over the uninvolved knee, then push with the uninvolved knee while pushing with the uninvolved hand to stand.

**NOTE: Keep the involved knee (and foot, if necessary) blocked with your knees (and feet).**

12. Have the resident pivot on the uninvolved foot while you assist in pivoting the involved foot.

**NOTE: Neither of you should be twisting at the trunk to accomplish this.**

13. You are now standing in front of the chair. Ask the resident to reach back and take hold of the armrest farthest from the bed with the uninvolved hand.

**NOTE: Occasionally, depending on the resident's balance, you may ask the resident to reach for the armrest prior to accomplishing the pivot. This should be done with caution because it can result in the resident losing his/her balance.**

14. Ask the resident to lean forward over the uninvolved knee and lower into the chair. Bend your hips and knees as the resident sits.

15. To assist the resident back to bed, reverse the steps of the procedure.

Transferring the resident with generalized weakness:

1-6. Repeat steps 1-6 of the procedure for transferring the resident with one-sided weakness.

7. Stand directly in front of the resident.

8. Block both of the resident's feet and knees with your feet and knees.

9. Place your arms around the resident under his/her arms and grasp the belt in the back.

10. Have the resident place his/her hands on the bed next to his/her hips.

11. Count to three and say "lift." On "lift," have the resident lean forward over both knees, then push with both knees and hands to stand.

NOTE: **Keep the feet and knees blocked as much as needed; but allow the resident to do as much of the work as possible.**

12. Have the resident pivot both feet while you assist as needed.

NOTE: **Neither of you should be twisting at the trunk to accomplish this.**

13. You are now standing in front of the chair. Ask the resident to reach back with both hands and take hold of the armrests. This can be done one at a time for increased stability, or both at the same time depending on the resident's abilities.

14. Ask the resident to lean forward over the knees and lower into the chair. Bend your hips and knees as the resident sits, assisting only as needed.

15. To assist the resident back to bed, reverse the steps of the procedure.

Transferring the resident following orthopedic surgery:

NOTE: **It is important that you are aware of any precautions or restrictions (i.e., weight-bearing status, amount of movement allowed at the operated joint, etc.) the physician has placed on the resident because of the surgery performed. The most typical resident will be one who has undergone knee or hip surgery, especially total knee or total hip joint replacement.**

1-5. Repeat steps 1-5 of the procedure for transferring the resident with one-sided weakness.

6. Have the resident move forward so he/she is sitting on the edge of the chair and so his/her uninvolved foot is flat ton the floor. The involved (operated) leg (knee) should generally remain extended out in front of the resident. If the resident cannot move forward independently, you may need to assist him/her.

7. Stand in front of the resident toward the uninvolved side.

8. Block the resident's uninvolved foot and knee with your feet and knees. If you are familiar with the resident's abilities, you may be able to block the uninvolved foot and knee with your foot and knee nearest the wheelchair.

    NOTE: **Spread your feet slightly (be careful if using both of your feet to block the resident's foot) to increase your base of support and, if needed, bend at the hips and knees, not the back.**

9. Place your arms around the resident under his/her arms and grasp the belt in the back.

10. Have the resident place his/her hands on the bed next to his/her hips.

11. Count to three and say "lift." On "lift," have the resident lean forward over the uninvolved knee, then push with the uninvolved knee while pushing with both hands to stand.

    NOTE: **Keep the uninvolved knee (and foot, if necessary) blocked with your knees (and feet) only as much as needed.**

12. Have the resident pivot on the uninvolved foot while you assist with the involved foot/leg.

    NOTE: **Neither of you should be twisting at the trunk to accomplish this.**

13. You are now standing in front of the chair. Ask the resident to reach back with both hands and take hold of the armrests.

14. Ask the resident to lean forward over the uninvolved knee and lower into the chair. Bend your hips and knees as the resident sits on the edge of the chair.

    NOTE: **It is important for this resident to sit close to the edge of the chair to make sure all restrictions in joint movement are followed. If the resident was placed toward the back of the seat, he/she could bend the hip or knee too much, causing pain or other problems.**

15. To assist the resident back to bed, reverse the steps of the procedure.

E. Transfer of resident to a car (dependent, assisted, or active); same procedure as C or D with the following considerations:

1. The side to which you will transfer the resident will depend upon which car seat he/she will sit in. Usually the front passenger seat is used because it is more accessible (larger front door) and allows the resident more room once in the car.

2. Exercise care as you guide the resident's head and hands safely inside the car to avoid bumping or injury.

3. Utilize the transfer technique most appropriate for that resident.

4. Be sure to get help as needed.

VI. Summary and Conclusion

A. Definition of transfer

B. Determinants for transfer

C. Types of transfers

D. Hints in transfers

E. Steps of procedures for transferring residents

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. Why is it important before beginning any transfer to have a "handle?" How is this accomplished?
2. What kind of transfer requires you to do all the lifting?
3. Does the resident ever need to reach around the RNA's neck to complete a transfer? Why or why not?
4. Why is it important to establish a verbal cue system prior to transferring the resident?
5. Why is it so important to have an accurate knowledge of the resident's diagnosis; whether they are injured, afraid, or confused?
6. Why does it make sense to use a mechanical (hydraulic) lift when transferring a paraplegic back to bed?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates transfer procedures and students return the demonstrations.
2. As a group, take turns performing a two-person lift. Be sure to observe proper application of transfer belt, good body mechanics and if students are pivoting instead of twisting.

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

Match the terms listed below to the correct definitions by writing the appropriate letter in the blank.

____ 1. Resident definitely requires help, but contributes half the effort

____ 2. Methods of moving a resident from one surface to another

____ 3. Resident requires no assistance; performs activity safely alone and feels secure

____ 4. Resident requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

____ 5. Resident contributes little or nothing toward execution of activity; is totally dependent

____ 6. Resident requires hand contact because of occasional loss of balance (protective safeguard)

____ 7. Resident lacks the necessary strength or mental capability to perform any part of the activity or performance is impractical

____ 8. Resident requires small amount of help to accomplish activity

a. Maximal assist

b. Stand-by assist

c. Unable

d. Minimal assist

e. Independent

f. Transfers

g. Moderate assist

h. Contact guarding

9. List the two determinants for a transfer.

a.

b.

10. Differentiate between passive transfers and active-assisted transfers.

11. List five hints in transfer.

    a.

    b.

    c.

    d.

    e.

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS: NAME OF STUDENT: ____________________

## SPECIFIC TRANSFER TECHNIQUES

Equipment:
1. Transfer belts
2. Various surfaces (i.e., bed, mat, car)
3. Various chairs (i.e., wheelchair, geri-chair, straight-back chair)

| DID THE STUDENT | YES | NO |
|---|---|---|
| Two-Person Lift (Passive Transfer)<br>1. Place wheelchair parallel to or slightly diagonal to side of bed. | | |
| 2. Lock brakes of chair. | | |
| 3. Remove arm of wheelchair next to bed. | | |
| 4. Swing away or remove leg rests. | | |
| 5. Slide or assist resident to edge of bed. | | |
| 6. Take position as lifter at back of resident. | | |
| 7. As lifter at back of resident, assist resident to a sitting position on bed, holding resident in sitting position if resident exhibits weakness. | | |
| 8. As lifter at back of resident, place arms under resident's arms and around rib cage of resident, grasping resident's left forearm/wrist with own right hand, and resident's right forearm/wrist with own left hand. | | |
| 9. Widen base of support by placing feet apart and bending knees and hips (not bending back). | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 10. As lifter at resident's legs, place arm that is toward resident's head as far under resident's thighs as possible, while other arm supports resident's lower legs at or just above the ankles. | | |
| 11. Instruct resident to pull his/her elbows toward his/her ribs as lift takes place. | | |
| 12. On the count of three and the command to "lift," straighten own hips and knees, lifting and placing resident in chair or on bed. | | |
| Two-Person Lift for Resident with Shoulder Problem<br>1. Place wheelchair parallel to or slightly diagonal to side of bed. | | |
| 2. Lock the brakes of chair to prevent it from moving during the transfer. | | |
| 3. Remove armrest of wheelchair next to bed. | | |
| 4. Swing away or remove leg rests of chair. | | |
| 5. Slide or assist resident to edge of bed. | | |
| 6. Take position as lifter at back of resident. | | |
| 7. As lifter at back of chair, assist resident to a sitting position on bed, holding resident in the sitting position if resident exhibits weakness. | | |
| 8. As lifter at front, put transfer belt around resident snugly. | | |
| 9. As lifter at back, put own arms around resident and under resident's arms; grasping transfer belt in front. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 10. Widen base of support by placing feet apart and bending knees and hips (not bending back). | | |
| 11. As lifter at legs place arm that is toward resident's head as far under resident's thighs as possible, while other arm supports resident's lower legs at or just above the ankles. | | |
| 12. Instruct resident to pull his/her elbows toward his/her ribs as lift takes place. | | |
| 13. On count of three and command to "lift," straighten hips and knees, lifting and placing resident in chair or on bed. | | |
| Dependent Standing Pivot Transfer (Passive Transfer) | | |
| 1. Place transfer belt around resident's waist. | | |
| 2. Place wheelchair and resident at slight angle to or parallel to surface to which resident is to be transferred. | | |
| 3. Lock brakes of wheelchair. | | |
| 4. Remove armrest on transfer side. | | |
| 5. Lift pedals; swing away or remove both footrests and place resident's feet flat on floor. | | |
| 6. Slide resident forward in the chair using correct method. | | |
| 7. Block resident's feet by placing own feet in a "V" in front of resident's feet. | | |
| 8. Squat slightly and place own knees at front and slightly outside resident's knee caps. | | |
| 9. Lean resident forward and ask him/her to place his/her arms around shoulders (not neck). | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 10. Reach around resident and grasp belt in back (or place hands under the resident's buttocks). | | |
| 11. Count to three and in time with the count, use a backward rocking motion to develop momentum. On "lift" command, lean (rock) back, straightening legs and pulling resident's hips forward while blocking residents knees with own knees. | | |
| 12. Stand resident just far enough to clear wheel of chair. | | |
| 13. Pivot resident while continuing to block his/her knees and knees. | | |
| 14. Once pivoted, slowly squat and lean back as resident is lowered to transfer surface. | | |
| 15. Assist resident back into wheelchair by reversing steps. | | |
| Transfer of Resident with One-Sided Weakness<br>1. Place transfer belt around resident's waist. | | |
| 2. Place wheelchair parallel to or slightly diagonal to side of bed so resident is moving toward his/her stronger side. | | |
| 3. Lock brakes on wheelchair. | | |
| 4. Leave armrests in place if resident is able to assist; if resident is unable, remove armrests. | | |
| 5. Lift pedals of chair, swing away or remove leg rests. | | |
| 6. Have/assist resident move forward so his/her feet are flat on floor and slightly apart. | | |
| 7. Stand in front of resident slightly toward resident's involved side. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 8. Block resident's involved foot and knee with own feet and knees. | | |
| 9. Place own arm around resident under uninvolved arm and over involved arm if resident is unable to use it. Grasp belt in back. | | |
| 10. Have resident place his/her uninvolved hand on the bed next to his/her hip. | | |
| 11. On count of three and "lift" command, have resident lean forward over the uninvolved knee, then push with the uninvolved knee while pushing with the uninvolved hand to stand. | | |
| 12. Have resident pivot on uninvolved foot while assisting him/her in pivoting involved foot. | | |
| 13. Standing in front of chair, ask resident to reach and take hold of armrest farthest from bed with uninvolved hand. | | |
| 14. Ask resident to lean forward over the uninvolved knee and lower into chair; bending own hips and knees as resident sits. | | |
| 15. Assist resident back to bed by reversing the steps of procedure. | | |
| Transferring the Resident with Generalized Weakness<br>1. Place a transfer belt around resident's waist. | | |
| 2. Place wheelchair parallel to or slightly diagonal to side of bed so resident is moving toward his/her stronger side. | | |
| 3. Lock brakes on wheelchair. | | |
| 4. Leave armrests in place if resident is able to assist; if resident is unable, remove armrests. | | |
| 5. Lift pedals of chair, swing away or remove leg rests. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 6. Have/assist resident move forward so his/her feet are flat on floor and slightly apart. | | |
| 7. Stand directly in front of resident. | | |
| 8. Use correct body mechanics to block both of resident's feet and knees with own feet and knees. | | |
| 9. Place arms around the resident under his/her arms and grasp the belt in the back. | | |
| 10. Have the resident place his/her hands on the bed next to his/her hips. | | |
| 11. On count of three and "lift" command, have resident lean forward over both knees, then push with both knees and hands to stand, keeping resident's feet and knees blocked as much as needed but allowing resident to do as much of the work as possible. | | |
| 12. Have resident pivot both feet while assisting as needed. | | |
| 13. Standing in front of chair, ask resident to reach back with both hands and take hold of armrests one at a time, or both at same time, depending on the resident's abilities. | | |
| 14. Ask resident to lean forward over the knees and lower into chair. Bend own hips and knees as resident sits, assisting only as needed. | | |
| 15. Assist resident back to bed by reversing the steps of procedure. | | |
| Transferring the resident following orthopedic surgery:<br>1. After checking for precautions or restrictions for resident as ordered by physician and determining that transfer is allowable, place transfer belt around resident's waist. | | |
| 2. Place wheelchair parallel to or slightly diagonal to side of bed so resident is moving toward his/her stronger side. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 3. Lock brakes on wheelchair. | | |
| 4. Leave armrests in place if resident is able to assist; if resident is unable, remove armrests. | | |
| 5. Lift pedals of chair, swing away or remove leg rests. | | |
| 6. Have/assist resident move forward so his/her uninvolved foot is flat on floor. Involved leg should remain extended out in front of resident. | | |
| 7. Stand in front of resident toward the uninvolved side. | | |
| 8. Use correct body mechanics to block resident's uninvolved foot and knee with own feet and knees. | | |
| 9. Place arms around resident under his/her arms and grasp belt in back. | | |
| 10. Have resident place his/her hands on bed next to his/her hips. | | |
| 11. On count of three and "lift" command, have resident lean forward over the uninvolved knee, and push with the uninvolved knee while pushing with both hands to stand, keeping the uninvolved knee (and foot, if necessary) blocked with own knees (and feet) only as much as needed. | | |
| 12. Have resident pivot on uninvolved foot while assisting with involved foot/leg. | | |
| 13. Standing in front of chair, ask resident to reach back with both hands and take hold of armrests. | | |
| 14. Ask resident to lean forward over uninvolved knee and lower into chair. Bend own hips and knees as resident sits on edge of chair. Make sure resident is close to edge of chair and not too far back in seat. | | |
| 15. Assist resident back to bed by reversing the steps of procedure. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| Transfer of Resident to a Car<br>(Dependent, Assisted, or Active)<br>**NOTE: This part of the evaluation can be omitted if conditions preclude availability of a car for simulation of procedure.** | | |
| 1. Determine which side resident is to be transferred to, based on which car seat he/she will occupy. | | |
| 2. Exercise care while guiding resident's head and hands safely inside car. | | |
| 3. Utilize transfer technique most appropriate for resident. | | |
| 4. Get help as needed. | | |

The student has satisfactorily completed the procedure "SPECIFIC TRANSFER TECHNIQUES" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 12

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1. g
2. f
3. e
4. b
5. a
6. h
7. c
8. d
9. Efficiency and safety, in any order.
10. Passive (dependent) transfers involve little or no help from the resident with the RNA performing nearly all of the transfer. Active (assisted or independent) transfers imply that the resident will perform a considerable amount of the transfer with assistance from the RNA or the RNA simply standing by to assure the resident's safety.
11. The student may list any five of the following in any order:
    a. Moving toward a stronger side is useful.
    b. When standing, the person with one stronger leg usually can transfer better when moving that side of his/her body toward the transfer object.
    c. With generalized muscle involvement, a stronger arm may be used as a stabilizer during standing and pivoting and thus may determine the direction.
    d. If transfer occurs while sitting with movement toward the side, the resident will move in the direction of his/her stronger arm.
    e. Sitting transfers can also be done by moving forward or backward to the object. (Good trunk balance is needed.)
    f. Equalize the height of the transfer surface.
    g. Support of feet will increase resident's stability during sitting transfers.
    h. When standing to transfer, move the head and trunk forward so the center of gravity is brought forward. This helps the resident to stand with minimal effort.
    i. Always explain the details of the transfer procedure to the resident prior to transferring.

TM 1

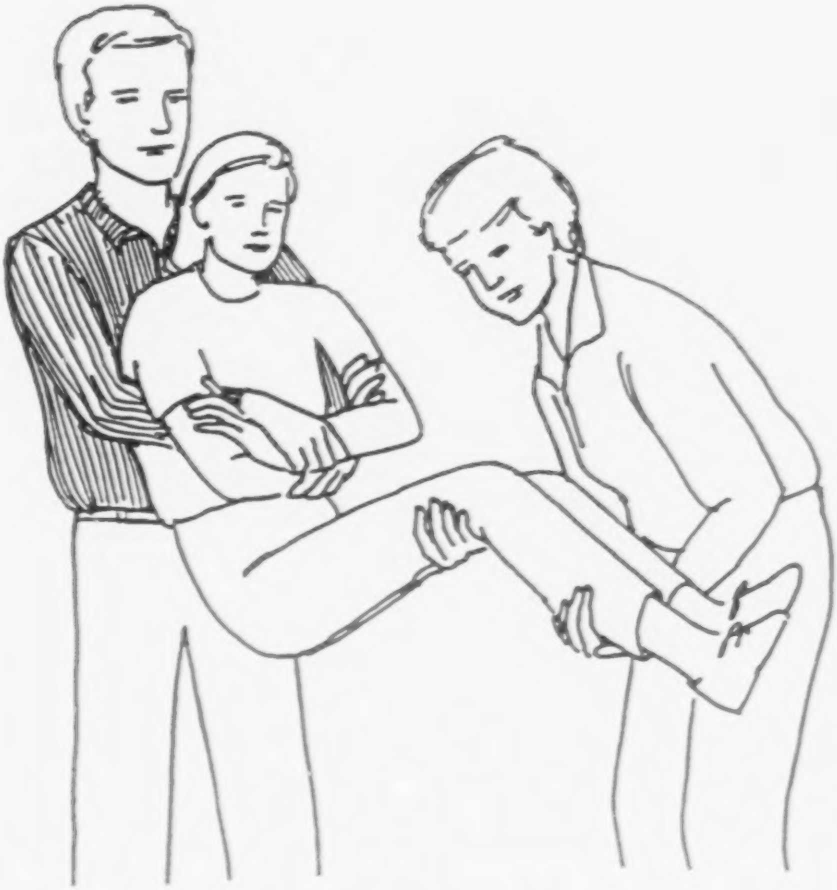
# Determinants

## for Transfer

1. Efficiency

2. Safety

# Passive (Dependent) Transfer

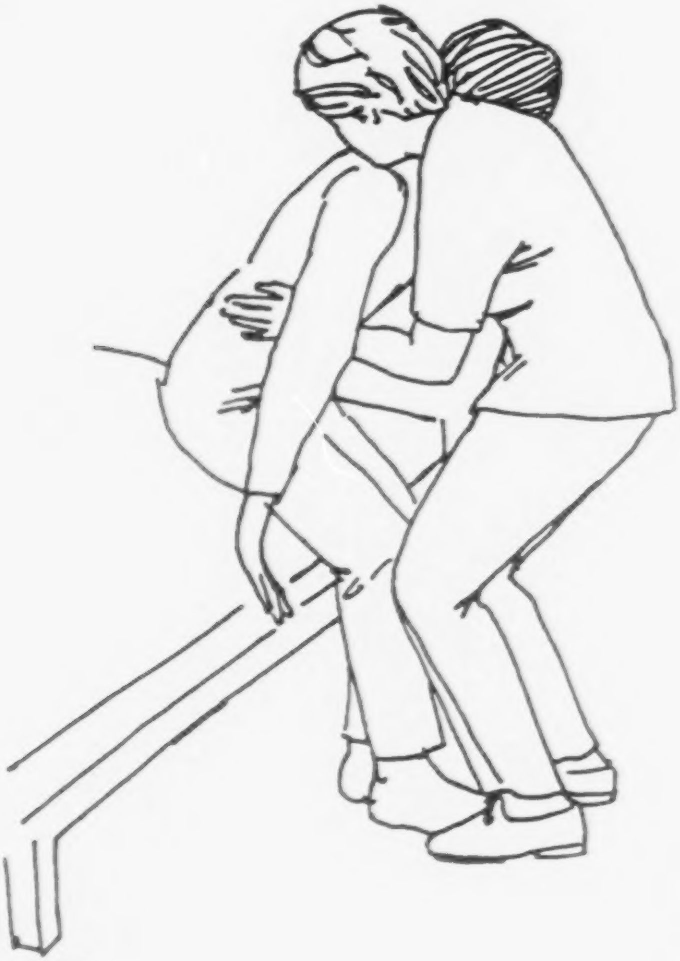


The Resident Cannot Help

# Active Transfer

## (Assisted or Independent)

May be Assisted or Independent



The Resident Helps or Does it Alone

# Hints in Transfer

1. Moving toward a stronger side is useful.

2. When standing, the person with one stronger leg usually can transfer better when moving that side of his/her body toward the transfer object.

3. With generalized muscle involvement, a stronger arm may be used as a stabilizer during standing and pivoting and thus may determine the direction.

4. If transfer occurs while sitting with movement toward the side, the resident will move in the direction of his/her strong arm.

5. Sitting transfers can also be done by moving forward or backward to the object. (Good trunk balance is needed.)

6. Equalize the height of the transfer surface.

7. Support of resident's feet will increase his/her stability during sitting transfers.

8. When standing to transfer, move the head and trunk forward so the center of gravity is brought forward. This helps resident to stand with minimal effort.

9. Always review with residents, the procedure prior to initiating the transfer.

LESSON PLAN: 13

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-13 AND DEMONSTRATION: VII-13

## AMBULATION DEVICES AND ACTIVITIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. State how parallel bars are of value with regard to the ambulation process.
2. Identify assistive ambulatory devices discussed in class.
3. Identify true statements related to checking the fit of assistive ambulatory devices identified in class.
4. Identify the first step in preparing a resident for ambulation.
5. State the position of the RNA during ambulation of a resident.
6. Identify key points in ambulation activities.
7. Demonstrate specific ambulation procedures.
    a. Assisting the orthopedic resident to stand and sit with crutches
    b. Assisting the hemiplegic resident to stand and sit with a cane
    c. Assisting the weak resident to stand and sit with a walker
    d. Assisting the orthopedic resident to stand and sit with a walker

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Parallel Bars
2. TM 2: Position of RNA During Ambulation
3. TM 3: Assisting the Orthopedic Resident to Stand with Crutches
4. TM 4: Assisting the Orthopedic Resident to Sit with Crutches
5. TM 5: Assisting the Hemiplegic Resident to Stand with a Cane
6. TM 6: Assisting the Hemiplegic Resident to Sit with a Cane
7. TM 7: Assisting the Weak Resident to Stand with a Walker
8. TM 8: Assisting the Weak Resident to Sit with a Walker
9. HO 1: Crutches
10. HO 2: Crutch Accessories
11. HO 3: Canes
12. HO 4: Walkers
13. Various ambulatory devices including crutches, canes, quad canes, walkers, parallel bars (if available)
14. Transfer belts
15. Wheelchair

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be ready to discuss various assistive devices encountered during employment as CNA.

REFERENCES: (Instructor's Additional Information)

Martin, James A. Physical Therapy Aide. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia, 1987.

Minor, Mary A. Duesterhaus and Scott Duesterhaus Minor. Patient Care Skills: Positioning, Range of Motion, Transfers, Wheelchairs and Ambulation. Reston VA: Reston Publishing Company, Inc., 1990.

INTRODUCTION:

If you are to work with restorative and maintenance level residents, you must have a comprehensive working knowledge of ambulatory devices and how to use them, as well as how to assist a resident to ambulate safely. Under the guidance of the therapist or therapy assistant, you will be ambulating a variety of residents with a variety of considerations. It is the **responsibility of the therapist to train the resident in how to ambulate with these devices. It is NOT the role of the RNA to participate in gait training, teaching the resident, or progressing a resident from one assistive device to another.** The RNA should, however, be aware that it is her/his responsibility to report any resident who is experiencing difficulty when ambulating either independently or with assistance.

LESSON PLAN: 13

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Equipment Used in Ambulation

  A. Parallel bars (TM 1)

    1. Used to prepare residents for independent gait (ambulation) or ambulation with advanced assistive devices (i.e., crutches, walkers, canes)

    2. Enables therapist to teach resident the gait pattern (foot and device placement) before leaving the bars; therapist stands inside the bars with the resident

    3. Can provide a more secure environment for resident who is working on maintenance level balance exercises, or has decreased endurance following illness.

  B. Crutches (HO 1) (II-1)

    1. Axillary crutches (good support for trunk)

      a. Standard wooden crutch

        1) Most commonly used

        2) Most reasonably priced (can be rented)

        3) Adjustable in both hand grip and length

        4) Sizes - dependent on height of resident

      b. Aluminum crutch

        1) Similar in style to wooden crutch

        2) Heavy-duty - will not split or crack

        3) Two to three times more expensive than a wooden crutch

        4) Sizes - dependent on height of resident

    2. Other types of crutches

      a. Forearm crutch (Lofstrand)

1) Single adjustable aluminum tube attached to a curved steel shank

2) Has a rubber covered hand bar and metal forearm cuff

3) Metal cuff and bar help stabilize wrist so resident can open doors and use hand without losing crutch

4) Can be used only on one side when patient needs more support than a cane but not two crutches

5) Also good for paraplegic residents (used bilaterally)

b. Kenny

1) Similar to axillary crutch except has complete circle cuff at top instead of axillary bar

2) Used with polio and some cerebral palsy (CP) residents

c. Aluminum trough forearm crutch

1) Trough with handle on top of single adjustable aluminum tube

2) Used with resident who cannot put weight on wrist and hand (example: arthritic resident)

3. Accessories (HO 2)

a. Axillary pads - rubber pads to cushion the axillary bar on any axillary crutch

b. Hand grip pads - rubber pads to cushion the hand grip bar

c. Tips - rubber; large safety grip is best as it will hold at any angle

C. Canes (HO 3)

1. Uses

a. Aid in ambulation

b. Maintain balance

- c. Promote confidence
- d. Improve stability
- e. Assist in supporting up to 30% of weight from leg (70% must be taken on leg)

2. Types of canes - can be made from wood, aluminum, or steel
   - a. Standard cane (usually wooden or aluminum) - also called straight cane
     - 1) Adjustable length - adjustments/fitting are made by the therapist
       - a) Wooden cane is cut to desired length.
       - b) Aluminum canes may have telescope feature for adjusting length.
     - 2) Types of standard canes - available in a variety of shapes and positions of hand grip
       - a) Curved handle ("J" cane)
       - b) "T" cane
       - c) Ortho-cane
         - (1) Places weight directly under the hand of the resident
         - (2) Greater balance and control
         - (3) Can use ortho-grip (finger depressions similar to those found on bicycle handlebar grips)
   - b. Quad cane
     - 1) Four legs have contact with floor
     - 2) Adjustable length
     - 3) Gives more support as long as all four tips touch floor
     - 4) Types of quad canes

            a) Small based quad cane

            b) Wide based quad cane

        c. Walk cane

            1) Combination of walker and cane

            2) Used like a cane in one hand next to the body (not in front of the body like a walker)

    D. Walkers (HO 4)

        1. Uses

            a. Limited use in some environments due to barriers and potential hazards such as stairs, carpet, etc.

            b. Requires partial strength of hands and wrists; strong elbow extensors and shoulder depressors

            c. Used for more stability

        2. Characteristics of walkers

            a. Various sizes and shapes - usually adjustable in height (adjustment/fitting done by therapist)

            b. Attachments available to meet needs of the resident (such as platform when weight bearing on hand and wrist is contraindicated)

        3. Types of walkers

            a. Standard walker (pick up walker)

            b. Rolling walker (may hear this referred to incorrectly as a wheeled walker)

            c. Wheeled walker (different than a rolling walker)

II. Checking the Fit of Ambulation Aids

    A. The therapist would have already adjusted and fit the appropriate ambulation device for the resident.

    B. To insure maximum safety during gait, the fit of the ambulation device should be checked every time the resident is ambulated.

C. Specific procedures for checking the fit

1. Parallel bars

a. Assist the resident to stand using the appropriate procedure.

b. Ask/assist resident to stand up straight with shoulders relaxed, and his/her weight distributed as evenly as possible on both feet.

c. With hands resting on the bars, the elbows should be bent approximately 20-30 degrees. This can be verified as follows:

1) With hands relaxed over the bars at the resident's sides, the bar should be at the bend of the wrist; the resident should be able to bend the wrist under the bar.

2) The bar should be approximately at the level of the greater trochanter.

2. Axillary crutches

a. Assist resident to stand using the appropriate procedure.

b. Position crutch tips approximately two inches lateral and six inches anterior to the resident's toes on each side.

c. Ask/assist the resident to stand up straight with shoulders relaxed, and her/his weight distributed as evenly as possible on both feet.

d. Axillary pads should be approximately 2-3 finger widths below armpit.

e. With the resident gripping the hand grip pads, the elbows should be bent approximately 20-30 degrees. This can be verified as follows:

1) With the arms relaxed at the sides, the hand grip pads should be at the bend of the wrist.

2) The hand grip pads should be

approximately at the level of the greater trochanter.

3. Forearm crutches

    a. Assist resident to stand using the appropriate procedure.

    b. Position crutch tips approximately two inches lateral and six inches anterior to the resident's toes on each side.

    c. Ask/assist the resident to stand up straight, with shoulders relaxed, and his/her weight distributed as evenly as possible on both feet.

    d. With the resident gripping the hand grips, the elbows should be bent approximately 20-30 degrees. This can be verified as follows:

        1) With the arms relaxed at the sides, the hand grips should be at the bend of the wrist.

        2) The hand grips should be approximately at the level of the greater trochanter.

    e. The top of the forearm cuff should be approximately 1.5 inches below the elbow such that it doesn't interfere with elbow extension.

4. Canes

    a. Assist resident to stand using the appropriate procedure.

    b. Position cane tip on standard cane or center of quad cane and walkcane approximately six inches lateral to the resident's toes.

    c. Ask/assist the resident to stand up straight with shoulders relaxed, and her/his weight as distributed as evenly as possible on both feet.

    d. With the resident gripping the cane, the elbow should be bent approximately 20-30 degrees. This can be verified as follows:

        1) With the arms relaxed at the sides, the handle of the cane should be at the bend of the wrist.

2) The cane handle should be approximately at the level of the greater trochanter.

5. Walkers

a. Assist the resident to stand using the appropriate procedure.

b. Ask/assist the resident to stand up straight, with shoulders relaxed, and his/her weight distributed as evenly as possible on both feet.

c. With hands resting on the walker hand grips, the elbows should be bent approximately 20-30 degrees. This can be verified as follows:

1) With hands relaxed over the walker hand grips at the resident's sides, the bar should be at the bend of the wrist; the resident should be able to bend the wrist under the hand grip.

2) The hand grip should be approximately at the level of the greater trochanter.

III. Preparatory Procedures for Ambulation

- A. Place a transfer belt on the resident. (This will give you a handle for control of the resident should he/she lose his/her balance.) (II-1)
- B. Properly position and lock the wheelchair in place.
- C. If resident is orthopedic (i.e., hip fracture, knee replacement, etc.) check weight-bearing status and other precautions or restrictions. (II-2)
- D. Position of RNA during ambulation (generally the same with all residents) (TM 2) (II-3, II-4)
    - 1. Stand on weak or involved side of resident.
    - 2. Stand slightly behind the resident (1/2 step).
    - 3. Place hand nearest the resident with palm up on back of walking belt.
    - 4. Place the other hand on or in front of shoulder/upper trunk on involved side.

IV. Steps of Procedures for Ambulating Residents

- A. Assisting the orthopedic resident to stand with crutches (TM 3)

    REMINDER: **Know resident's diagnosis and check for weight-bearing status or restrictions (i.e., avoiding hip flexion)**

    - 1. Before coming to a standing position, the wheelchair must be properly positioned and locked. The stronger leg is placed on the floor and the footrest on the side of the wheelchair is removed or swung out of the way and the foot pedal is raised.
    - 2. Carefully support the involved leg as the footrest or leg rest on this side is removed or swung out of the way. This allows room for maneuverability.
        - a. If the resident is unable to bend his/her knee, and an elevating leg rest is used to support the leg while sitting, the leg rest must be removed or pivoted to the side before the resident stands. This is true any time an elevating leg rest is used.
        - b. To accomplish this, the RNA supports the

involved leg with one hand and removes the leg rest with the other hand.

3. The resident then moves to the front edge of the seat of the wheelchair. Assist the resident as needed.

   **NOTE: Crutches must be placed close at hand before the resident starts moving forward.**

4. The involved leg should be carefully lowered to the floor before the resident attempts to stand.

5. Using the handgrips, the resident grasps both crutches with the hand (palm down) on the involved side. The resident pushes to a standing position using the crutches on the involved side and the armrest of the wheelchair on the noninvolved side.

6. The RNA assists and holds the resident by grasping the gait belt with one hand (palm up) while the other hand is positioned on or in front of the shoulder/upper trunk on the involved side. If the resident needs more help, an assistant can be positioned on the resident's noninvolved side using the same hand placement as the RNA (one hand grasping the gait belt in back, the other hand on or in front of the noninvolved shoulder/upper trunk).

7. Once the standing position is attained and the weight is being borne on the stronger/noninvolved side, the resident should position the crutches as follows:

   a. Reach across and grasp the outermost crutch with the hand on the noninvolved side and place the crutch under the arm, grasping the handgrip.

   b. While continuing to grasp the crutch on the involved side with the palm facing down, turn the hand and crutch toward the body, sliding the crutch underneath the arm. (The hand will be positioned with the fingers toward the body.)

   c. Once the crutch is under the arm, release the handgrip and reposition other hand with the thumb pointing toward the body.

8. Once the resident is standing with crutches properly positioned, verify the correct fit of the crutches as previously described.

9. The resident is now ready to walk while the RNA provides as much assistance as needed by holding the back of the gait belt with one hand and positioning the other hand in front of the resident's shoulder/upper trunk on the involved side.

B. Assisting the orthopedic resident to sit with crutches (TM 4)

1. To sit, the resident walks toward the wheelchair, turns with the stronger side toward the wheelchair, and backs up until the front edge of the wheelchair seat is felt against the back of the legs. The RNA stands on the involved side so that he/she is in a position to maneuver the involved leg.

2. The crutch on the resident's involved side is removed from the axilla and held by the handgrip only using the following procedure:

    a. While the crutch is still under the arm, remove the hand from the handgrip, turn the hand so the fingers move toward the body (the elbow will be sticking out) and grasp the hand grip with the palm facing down, the fingers next to the body and the thumb away from the body.

    b. Remove the crutch from under the axilla by turning the hand and arm out away from the body (bring the elbow toward the side).

    c. The resident holds the crutch out to the side by continuing to grasp the hand grip with the palm facing down.

3. The other crutch is then removed from the axilla, placed next to (in front of) the crutch held on the involved side, and both crutches are held by the hand grips on the resident's involved side (palm facing down).

4. With the RNA holding the gait belt with one hand and the resident's shoulder/upper trunk on the involved side with the other hand, the resident reaches for the wheelchair armrest with the hand on the noninvolved side.

5. As the resident lowers to a sitting position using the armrest on the noninvolved side and the crutches on the involved side, the RNA may need to

assist the resident in sliding the involved leg forward along the floor. The resident should sit down on the front edge of the wheelchair seat to avoid undue stress on the involved leg.

6. The resident's leg is then supported as needed as the resident moves back in the wheelchair and the involved leg is then placed in the appropriate position on the elevating leg rest. The crutches are placed to the side, and the resident can adjust his/her position in the wheelchair.

C. Assisting the hemiplegic resident to stand with a standard cane (TM 5)

1. Before starting, the wheelchair must be properly positioned, locked, the footrests removed or pivoted out of the way, and the foot pedals raised.

2. The resident scoots to the front edge of the seat. The RNA should assist as needed.

3. When using a standard cane, the resident holds the cane on the strong side while grasping the armrest.

4. The resident's feet are placed on the floor together or in stride (strong foot back), close to the front edge of the wheelchair seat. The resident's knees should be over or slightly in front of his/her feet.

5. Initiating the movement with trunk flexion, the resident then pushes to a standing position using one or both arms and straightening the legs.

6. The RNA stands slightly behind and to the resident's involved side (opposite the side with the cane). The hand nearest the resident grasps the belt in back, with the palm up, the other hand either grasps the belt in front or holds the resident's upper chest near the involved shoulder to assist the resident to stand as needed.

NOTE: **Most hemiplegic residents are prone to shoulder problems on the involved side and care must be taken to avoid grabbing the shoulder or upper arm to avoid undue stress on the shoulder.**

7. A resident who has the use of both arms places both hands on the respective armrests to assist in raising or lowering.

8. Once the resident is standing, verify the correct fit of the cane as previously described.

9. The resident is now ready to walk while the RNA provides as much assistance as needed by holding the gait belt in the back with one hand and positioning the other hand in front of the shoulder/upper trunk.

D. Assisting the hemiplegic resident to stand using a quad cane or walk cane

1. When a quad cane is used, the quad cane is positioned slightly in front and to the strong side of the resident.

2. The resident moves to standing as described when using a standard cane EXCEPT the resident pushes with the strong hand on the armrest or with both hands on the armrests.

NOTE: **The resident should not be allowed to grasp the quad cane or walk cane and attempt to push up on it when standing up or sitting down because it will not provide the support needed and could throw the resident off balance resulting in a fall.**

3. Once standing the resident grasps the quad cane and proceeds as previously described.

E. Assisting the hemiplegic resident to sit with a cane (TM 6)

1. To return to a sitting position, the resident walks to the wheelchair which should be properly positioned and locked, with the footrests and foot pedals out of the way.

2. The resident then turns, usually with the strong side toward the wheelchair, and backs up until the front edge of the wheelchair seat is felt at the backs of the knees.

3. When using a standard cane: the resident should reach back for the armrest on the strong side while continuing to grasp the cane. If able, the resident then reaches back with the weaker arm for the other armrest. The resident then lowers himself/herself into the wheelchair. The RNA should assist the resident to sitting as needed, using the gait belt.

4. When using a quad cane or walkcane: the resident should release the quad cane or walkcane and reach back for the armrest on the strong side, then the weak side, if able. Grasping the armrests, the resident then lowers himself/herself into the wheelchair.

5. The resident or RNA can then adjust the footrests and get the resident into a comfortable position in the wheelchair.

6. The RNA remains in the same relative position throughout, assisting when needed by controlling balance, turning, and lowering the resident into the wheelchair.

F. Assisting the weak resident to stand with a walker (TM 7)

1. The wheelchair must be positioned, locked, the foot pedals raised, and the footrests removed or swung out of the way.

2. The resident moves to the front edge of the wheelchair seat and places her/his feet on the floor close to the front edge of the wheelchair seat. Assist the resident as needed.

   NOTE: **Walker must be placed close at hand before the resident starts scooting forward.**

3. The feet should be under or slightly behind the knees in a stride position with the stronger foot back; both hands are on the armrests of the wheelchair. The walker is placed in front of and as close to the resident as possible.

4. Initiating with trunk flexion, the resident pushes to standing with both hands, straightening the legs.

5. The resident's hands are placed on the walker handgrips one at a time. Verify correct fit of walker according to steps previously described.

6. The RNA assists the resident as needed with one hand on the back of the gait belt and the other hand either in front of the resident's shoulder/upper trunk or on the front of the gait belt depending on how much assistance is needed. The RNA is positioned on the weaker side of the resident.

G. Assisting the weak resident to sit with a walker (TM 8)

1. To sit, the resident walks to the wheelchair, turns with the stronger side toward the wheelchair, and backs up until the front edge of the wheelchair seat is felt against the back of the legs.

2. The feet are in stride position, with the stronger leg back.

3. The resident reaches backward for the armrest with the arm on the stronger side first, flexes trunk forward, and reaches back with the other hand. (RNA steadies, as necessary).

4. The resident slowly lowers to a sitting position.

5. The resident adjusts the sitting position as needed.

6. The RNA moves as the resident moves throughout the procedure, maintaining a position behind and to the weaker side of the resident.

H. Assisting orthopedic resident to stand with a walker

REMINDER: **Know resident's diagnosis and check for weight-bearing status or restrictions** (i.e., **avoiding hip flexion**).

1. Before coming to a standing position, the wheelchair must be properly positioned and locked. The stronger leg is placed on the floor and the footrest on the side of the wheelchair is removed or swung out of the way and the foot pedal is raised.

2. Carefully support the involved leg as the foot pedal is raised and the footrest or leg rest on this side is removed or swung out of the way. This allows room for maneuverability.

   a. If the resident is unable to bend his/her knee, and an elevating leg rest is used to support the leg while sitting, the leg rest must be removed or pivoted to the side before the resident stands. This is true any time an elevating leg rest is used.

   b. To accomplish this, the RNA supports the involved leg with one hand and removes the leg rest with the other hand.

NOTE: **Whenever footrests and/or leg rests are swung out of the way, the foot pedals should always be raised to insure maximum safety for the resident and the RNA.**

3. The resident then moves to the front edge of the seat of the wheelchair. Assist the resident as needed.

   NOTE: **Walker must be placed close at hand before the resident starts scooting forward.**

4. The involved leg should be carefully lowered to the floor before the resident attempts to stand.

5. The feet should be in stride position with the stronger foot back; both hands are on the armrests of the wheelchair. The walker is placed in front of and as close to the resident as possible.

6. Initiating with trunk flexion, the resident pushes to standing with both hands, straightening the strong leg.

7. The resident's hands are placed on the walker hand grips one at a time. Verify correct fit of walker according to steps previously described.

8. The resident is now ready to walk while the RNA provides as much assistance as needed by holding the gait belt with one hand and positioning the other hand in front of the shoulder/upper trunk.

I. Assisting the orthopedic resident to sit with a walker

1. To sit, the resident walks to the wheelchair, turns with the stronger side toward the wheelchair, and walks backward until the front edge of the wheelchair seat is felt against the back of the legs.

2. The feet are in stride position, with the stronger leg back.

3. The resident reaches backward for the armrest with the arm on the stronger side first, flexes trunk forward, and reaches back for the other armrest with the other hand. (RNA steadies, as necessary).

4. With the RNA holding the gait belt with one hand and the resident's shoulder/upper trunk on the involved side with the other hand, the resident slowly lowers himself/herself into the wheelchair.

5. As the resident lowers to sitting, the RNA may need to assist the resident in sliding the involved leg forward along the floor. The resident should sit down on the front edge of the wheelchair seat to avoid undue stress on the involved leg.

6. The resident's leg is then supported as needed as the resident moves back in the wheelchair and the involved leg is then placed in the appropriate position on the elevating leg rest. The RNA assists as the resident adjusts her/his position in the wheelchair.

IV. Summary and Conclusion

A. Equipment used in ambulation

B. Checking the fit of ambulation aids

C. Preparatory procedures for ambulation

D. Steps of procedures for ambulating the resident

LESSON PLAN: 13

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. What would you do if a resident you were ambulating became dizzy?
2. What types of residents might use a cane? Walker? Crutches?
3. What is the position of the assistant during ambulation of a resident?
4. When might the RNA need assistance from another staff member to ambulate a resident?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES

1. Instructor demonstrates ambulation procedures and students return the demonstrations.

LESSON PLAN: 13

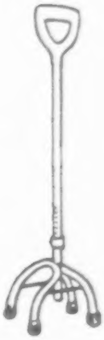
COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

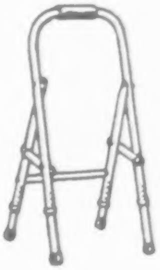
EVALUATION ITEMS:

1. How are parallel bars useful with respect to ambulation?

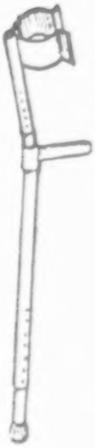
2. Identify the assistive ambulatory devices pictured below.



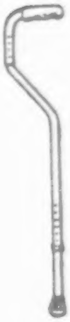
a. ____________________



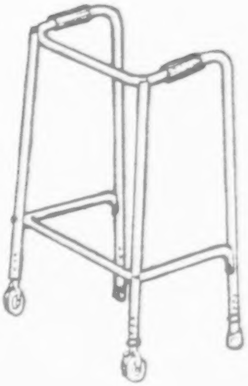
b. ____________________



c. ____________________



d. ____________________



e. ____________________

3. What is the first step in preparing a resident for ambulation?

4. When an orthopedic resident with crutches stands, the crutches are held on the side. (Circle the letter of the correct answer.)

   a. Noninvolved
   b. Involved

5. When getting ready to sit, the orthopedic resident with a walker, reaches back with hand on the ______ side first. (Circle the letter of the correct answer.)

   a. Stronger
   b. Weaker

6. When a hemiplegic resident is rising from a chair to use a cane, the position of the RNA is: (Complete the sentence in the space provided.)

For each of the following statements related to checking the fit of ambulation aids, write "T" if the statement is true, or "F" if it is false.

____ 7. The therapist is responsible for adjusting and fitting the appropriate ambulation device for a resident, not the RNA.

____ 8. The ambulation device should be checked by the RNA every two weeks.

____ 9. To tell if the parallel bars are the appropriate height for the resident, the resident should be able to bend the wrist under the bar and the bar should be approximately at the level of the greater trochanter.

____ 10. When checking the fit of axillary crutches, the axillary pads should be approximately 2-3 finger widths below the resident's armpit.

____ 11. The correct position of forearm crutch tips is approximately two inches lateral and six inches anterior to the resident's toes on each side.

____ 12. The forearm crutch cuff should fit around the resident's elbow.

____ 13. Canes should be positioned so that the tip on a standard cane or the center of a quad cane or walkcane is about six inches lateral to the resident's toes.

____ 14. It is not necessary for the resident to stand up straight when checking the fit of a walker.

LESSON PLAN: 13

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS: NAME OF STUDENT: ______________

SPECIFIC AMBULATION ACTIVITIES

Equipment:
1. Transfer belts
2. Wheelchair
3. Crutches
4. Standard cane
5. Quad cane
6. Walk cane
7. Walker

| DID THE STUDENT | YES | NO |
|---|---|---|
| Preparing for Ambulation of Resident<br>1. Place a transfer belt on the resident. | | |
| 2. Properly position and lock the wheelchair in place. | | |
| 3. If resident is orthopedic check weight-bearing status and other precautions or restrictions. | | |
| 4. Assume correct position of RNA for ambulation of resident. | | |
| a. Stand on weak or involved side of resident. | | |
| b. Stand slightly behind the resident (1/2 step). | | |
| c. Place hand nearest the resident with palm up on back of walking belt. | | |
| d. Place the other hand on or in front of shoulder/upper trunk on involved side. | | |

Assisting the Orthopedic Resident to Stand with Crutches

1. After checking resident's diagnosis/weight-bearing status/restrictions, properly position wheelchair and lock wheels; observe/assist resident as she/he places stronger leg on floor; remove/swing away footrest; raise foot pedal.

| DID THE STUDENT | YES | NO |
|---|---|---|
| 2. If resident is unable to bend his/her knee, and an elevating leg rest is used, support resident's involved leg with one hand and remove leg rest with the other hand. | | |
| 3. See that resident's crutches are close at hand. | | |
| 4. Observe/assist resident as he/she moves to front edge of seat of wheelchair. | | |
| 5. Carefully lower involved leg to floor before the resident attempts to stand. | | |
| 6. Observe/assist resident as he/she uses handgrips to grasp both crutches with hand of involved side, then pushes to standing position using crutches on involved side and armrest of wheelchair on noninvolved side. | | |
| 7. Hold resident by grasping gait belt (palm up) while other hand is positioned on or in front of the shoulder/upper trunk on involved side. If resident needs more help, an assistant should be positioned on resident's noninvolved side using same hand placement as the RNA. | | |
| 8. Once standing position is attained and weight is being borne on stronger/noninvolved side, observe/assist resident in proper positioning of crutches and verify correct fit. | | |
| 9. Assist resident as necessary while walking by holding back of gait belt with one hand and positioning other hand in front of shoulder/upper trunk on involved side. | | |
| Assisting the Orthopedic Resident to Sit with Crutches<br>1. Observe/assist resident as she/he walks toward wheelchair, turns with stronger side toward wheelchair, and backs up until front edge of the seat is felt against the back of the legs; stand on resident's involved side so that he/she is in a position to maneuver the involved leg. | | |
| 2. Observe/assist resident in as she/he follows correct procedures to remove crutch on involved side and holds it by handgrip. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 3. Observe/assist resident as he/she removes other crutch, transfers it to involved side, and holds both crutches by handgrips. | | |
| 4. Hold the gait belt and with one hand and the resident's shoulder/upper trunk on the involved side with the other hand, as resident reaches for the wheelchair armrest with the hand on noninvolved side. | | |
| 5. Assist resident in sliding involved leg forward along floor as resident lowers to sitting position using armrest on noninvolved side and crutches on involved side. Observe/assist as resident sits down on front edge of seat. | | |
| 6. Support resident's leg as needed as resident moves back in chair and involved leg is placed in appropriate position on leg rest; assist with placing crutches to the side if necessary; observe/assist resident as she/he adjusts his/her position in the wheelchair. | | |
| Assisting the Hemiplegic Resident to Stand with a Standard Cane<br>1. Properly position wheelchair and lock wheels; remove/swing away footrests; raise foot pedals. | | |
| 2. Observe/assist resident as she/he scoots to front edge of seat of wheelchair. | | |
| 3. Observe/assist resident as he/she holds standard cane in hand on strong side while grasping armrest. | | |
| 4. Observe/assist resident as she/he places feet on floor together or in stride (strong foot back) close to front edge of wheelchair seat. | | |
| 5. Observe/assist resident as he/she achieves standing position by initiating movement with trunk flexion and pushing with one or both arms. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 6. Stand slightly behind and to the resident's involved side (opposite the side with the cane), with hand nearest the resident grasping the belt in back with the palm up, and other hand either grasping the belt in front or holding the resident's upper chest near the involved shoulder to assist resident to stand as needed (being careful to avoid grasping the shoulder or upper arm of the involved side). | | |
| 7. Observe/assist resident who has use of both arms as she/he places both hands on respective armrests to assist in raising or lowering. | | |
| 8. Once resident is standing, verify correct fit of cane and assist resident to walk as needed by holding gait belt in back with one hand and positioning other hand in front of the shoulder/upper trunk. | | |
| Assist the Hemiplegic Resident to Stand using a Quad Cane or Walk Cane<br>1. Check to see that quad cane is positioned slightly in front and to the strong side of resident. | | |
| 2. Observe/assist resident as he/she achieves standing position by pushing with strong hand on armrest or with both hands on the armrests--not by grasping the quad cane or walk cane to provide support. | | |
| 3. Once resident is standing, verify correct fit of cane and assist resident to walk as needed by holding gait belt in back with one hand and positioning other hand in front of the shoulder/upper trunk. | | |
| Assisting the Hemiplegic Resident to Sit with a Cane<br>1. Observe/assist resident to return to a sitting position, as he/she walks to the wheelchair and checks that it is properly positioned, locked, and that footrests are out of the way. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 2. Observe/assist resident as resident turns (usually with strong side toward chair) and backs up until front edge of the wheelchair seat is felt at backs of knees. | | |
| 3. Observe/assist as needed with gait belt as resident using standard cane reaches back for armrest on strong side while continuing to grasp cane; if able he/she reaches back with weaker arm for the other armrest; resident then lowers self into wheelchair. | | |
| 4. Observe/assist as needed with gait belt as resident using quad cane or walkcane releases the cane and reaches back for the armrest on the strong side; if able she/he reaches back with weaker arm for the other armrest; resident then lowers self into wheelchair. | | |
| 5. Observe/assist resident to adjust footrests and adjust position in wheelchair. | | |
| 6. Remain in the same relative position throughout procedure, assisting when needed by controlling balance, turning, and lowering the resident into the wheelchair. | | |
| Assisting the Weak Resident to Stand with a Walker<br>1. Properly position wheelchair and lock wheels; remove/swing away footrests; raise foot pedals. | | |
| 2. Observe/assist resident as he/she moves to front edge of wheelchair seat and places feet on floor close to front edge of wheelchair seat. | | |
| 3. See that resident's walker is close at hand. | | |
| 4. Observe/assist resident as she/he positions feet in stride position with the stronger foot back and puts both hands on armrests of wheelchair. Check that walker is placed in front of and as close to resident as possible. | | |
| 5. Observe/assist resident as he/she achieves standing position by flexing trunk and pushing with both hands and straightening legs. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 6. Observe/assist resident as she/he places hands on walker handgrips one at a time. Verify correct fit of walker. | | |
| 7. Stand on resident's weaker side and assist resident as needed with one hand on back of gait belt and other hand either in front of resident's shoulder/upper trunk or on front of gait belt. | | |
| Assisting the Weak Resident to Sit with a Walker<br>1. Observe/assist resident as she/he walks toward wheelchair, turns with stronger side toward the wheelchair, and backs up until front edge of wheelchair seat is felt against back of legs; resident assumes stride position, with stronger leg back. | | |
| 2. Observe/assist resident as he/she reaches backward for the armrest with the arm on the stronger side first, flexes trunk forward, and reaches back with the other hand; steady resident if necessary. | | |
| 3. Observe/assist resident as she/he slowly lowers to a sitting position and adjusts to comfortable position. | | |
| 4. Moves as resident moves, maintaining a position behind and to the weaker side of resident. | | |
| Assisting the Orthopedic Resident to Stand with a Walker<br>1. After checking resident's diagnosis/weight-bearing status/restrictions, properly position wheelchair and lock wheels; observe/assist resident as she/he places stronger leg on floor; remove/swing away footrest; raise foot pedal. | | |
| 2. If resident is unable to bend his/her knee, and an elevating leg rest is used, support resident's involved leg with one hand and remove leg rest with the other hand. | | |
| 3. See that resident's walker is close at hand. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 4. Observe/assist resident as he/she moves to front edge of seat of wheelchair. | | |
| 5. Carefully lower involved leg to floor before the resident attempts to stand. | | |
| 6. Observe/assist resident as she/he positions feet in stride position with the stronger foot back and puts both hands on armrests of wheelchair. Check that walker is placed in front of and as close to resident as possible. | | |
| 7. Observe/assist resident as he/she achieves standing position by flexing trunk and pushing with both hands, straightening the strong leg. | | |
| 8. Observe/assist resident as she/he places hands on walker handgrips one at a time; verify correct fit of walker. | | |
| 9. Assist resident as necessary while walking by holding back of gait belt with one hand and positioning other hand in front of shoulder/upper trunk on involved side. | | |
| Assisting Orthopedic Resident to Sit with a Walker<br>1. Observe/assist resident as she/he walks toward wheelchair, with stronger side toward chair and backs up until front edge of wheelchair seat is felt against back of legs; resident assumes stride position, with stronger leg back. | | |
| 2. Observe/assist resident as he/she reaches backward for the armrest with the arm on the stronger side first, flexes trunk forward, and reaches back with the other hand; steady resident if necessary. | | |
| 3. Hold the gait belt with one hand and the resident's shoulder/upper trunk on the involved side with the other hand as resident slowly lowers self into wheelchair. | | |
| 4. Assist resident in sliding involved leg forward along floor as resident lowers to sitting position; observe/assist as resident sits down on front edge of seat. | | |

| DID THE STUDENT | YES | NO |
|---|---|---|
| 5. Support resident's leg as needed as resident moves back in chair and involved leg is placed in appropriate position on leg rest; observe/assist resident as she/he adjusts his/her position in the wheelchair. | | |

The student has satisfactorily completed the procedure "SPECIFIC AMBULATION ACTIVITIES" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 13

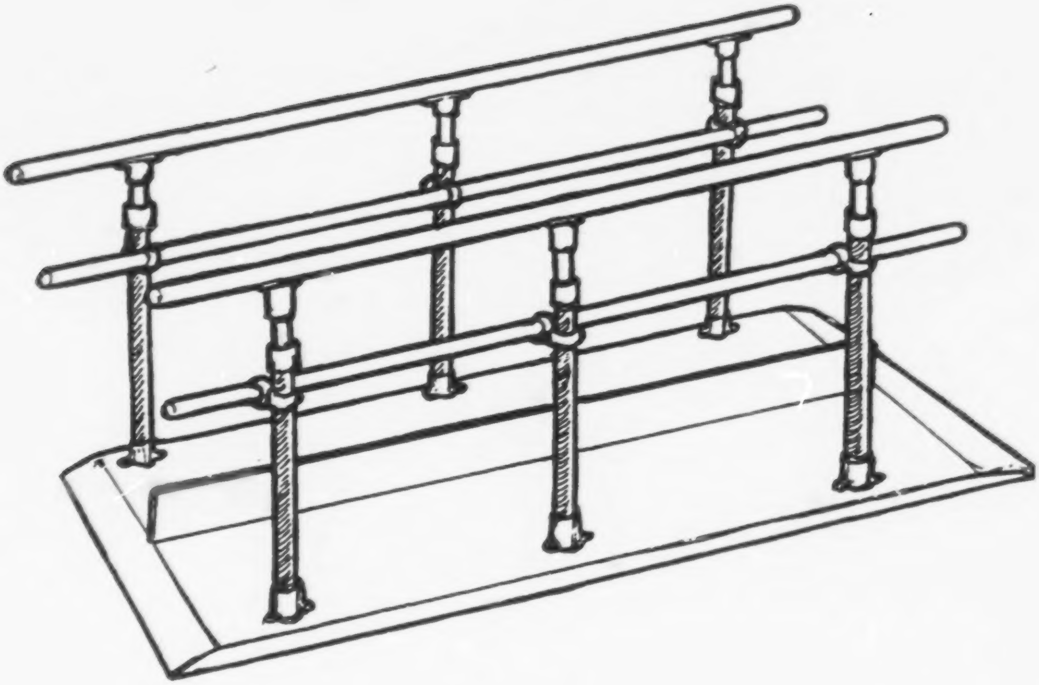
COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

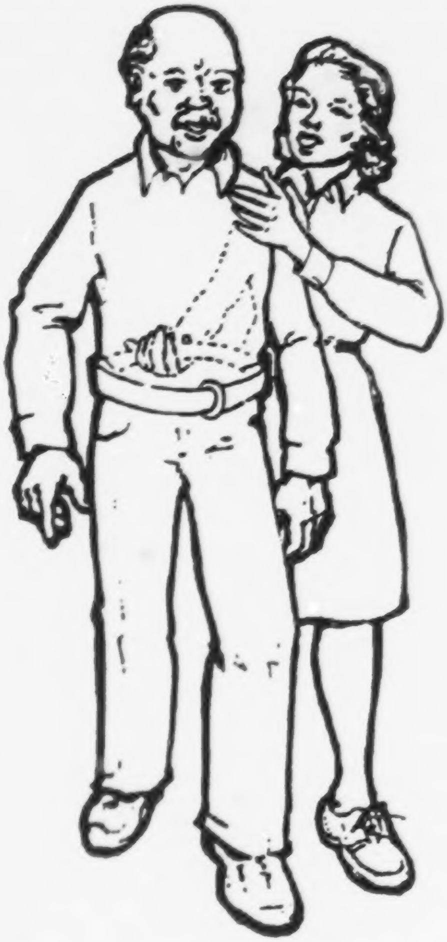
1. Parallel bars are used to prepare residents for independent ambulation or ambulation with advanced assistive devices.
2. a. Quad cane
   b. Walk cane
   c. Forearm crutch
   d. Ortho cane
   e. Rolling walker
3. Place a transfer belt on the resident.
4. b
5. a
6. Slightly behind and to the resident's involved side (opposite the side with the cane).
7. T
8. F
9. T
10. T
11. T
12. F
13. T
14. F

# Parallel Bars



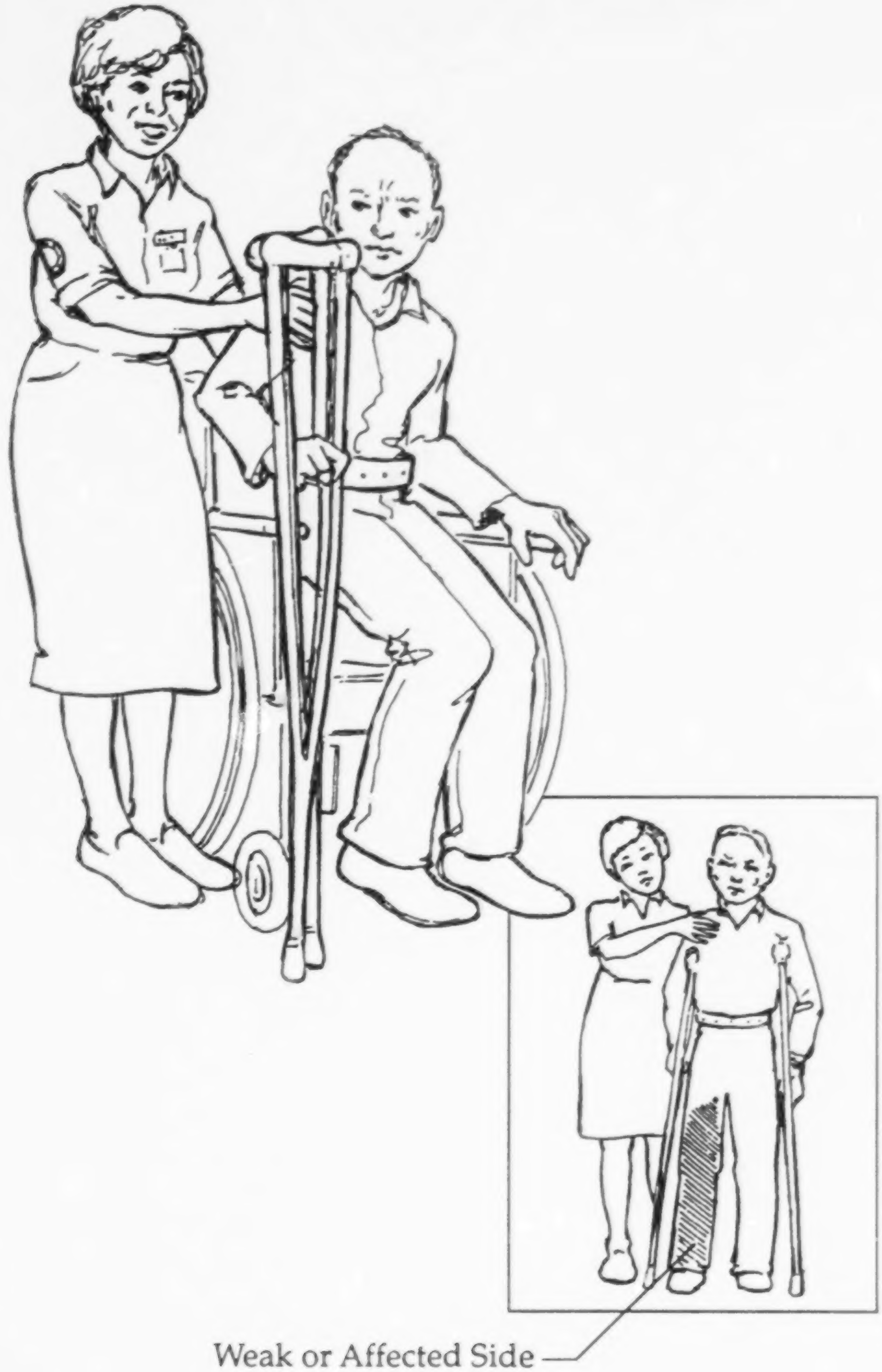
# Position of RNA

## During Ambulation

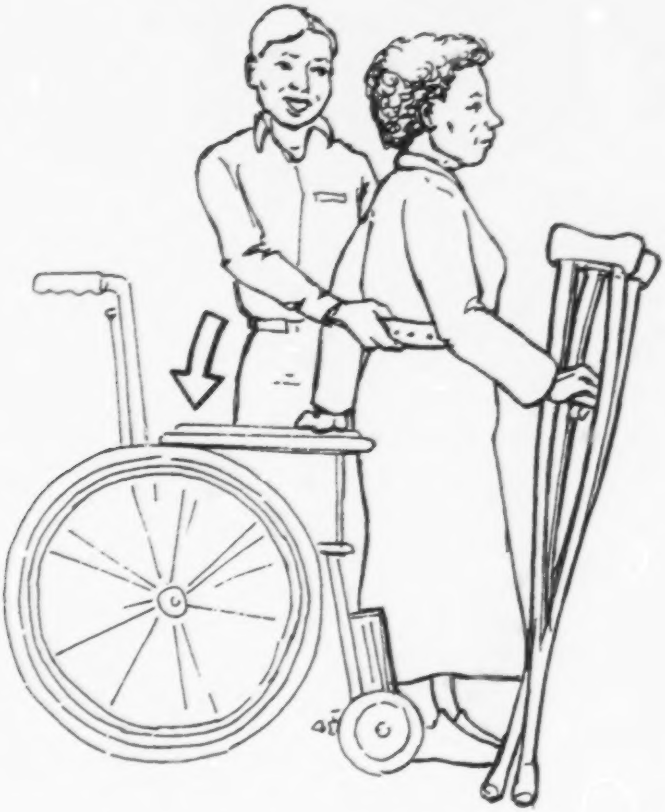


TM 3

# Assisting the Orthopedic Resident to Stand with Crutches


Weak or Affected Side

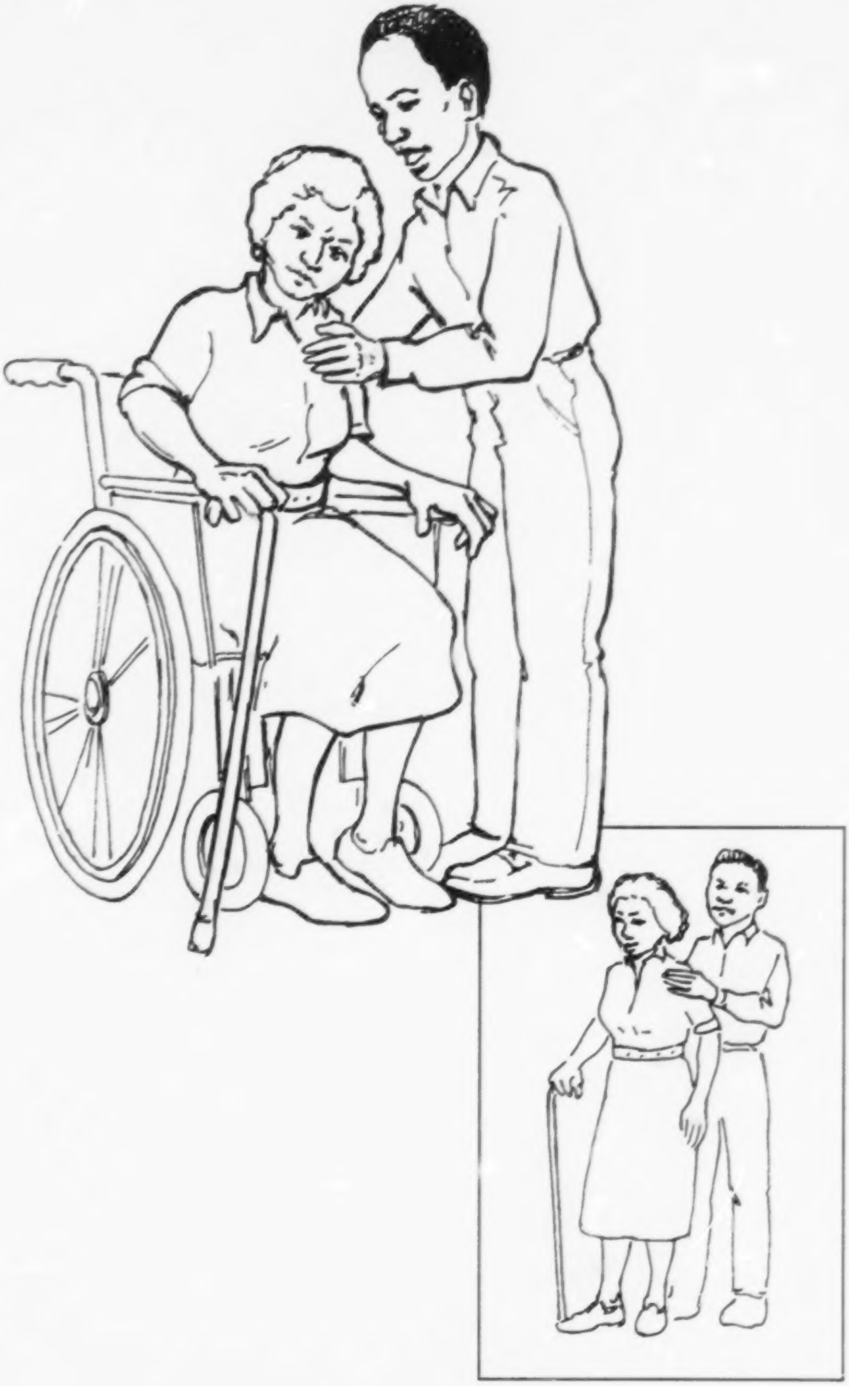
# Assisting the Orthopedic Resident to Sit with Crutches



TM 5

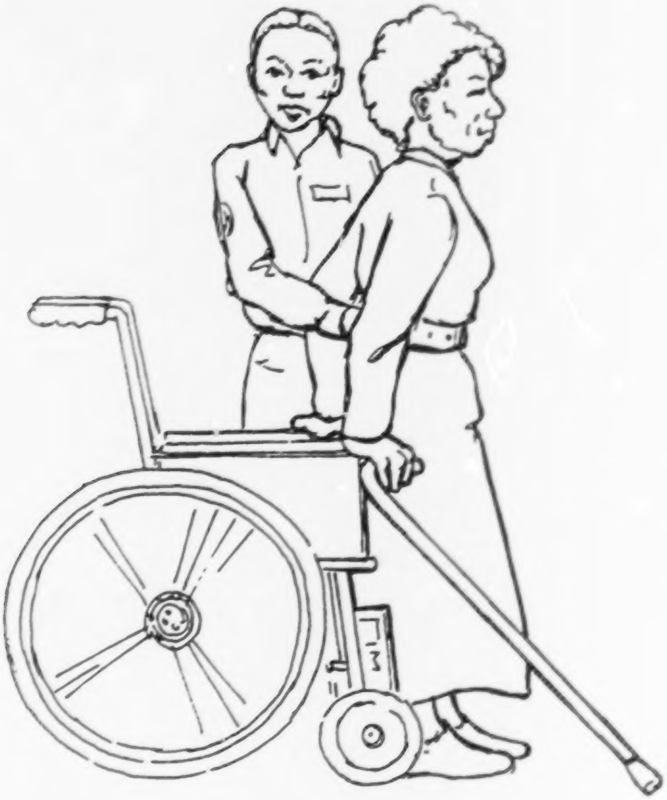
# Assisting the Hemiplegic

## Resident to Stand with a Cane



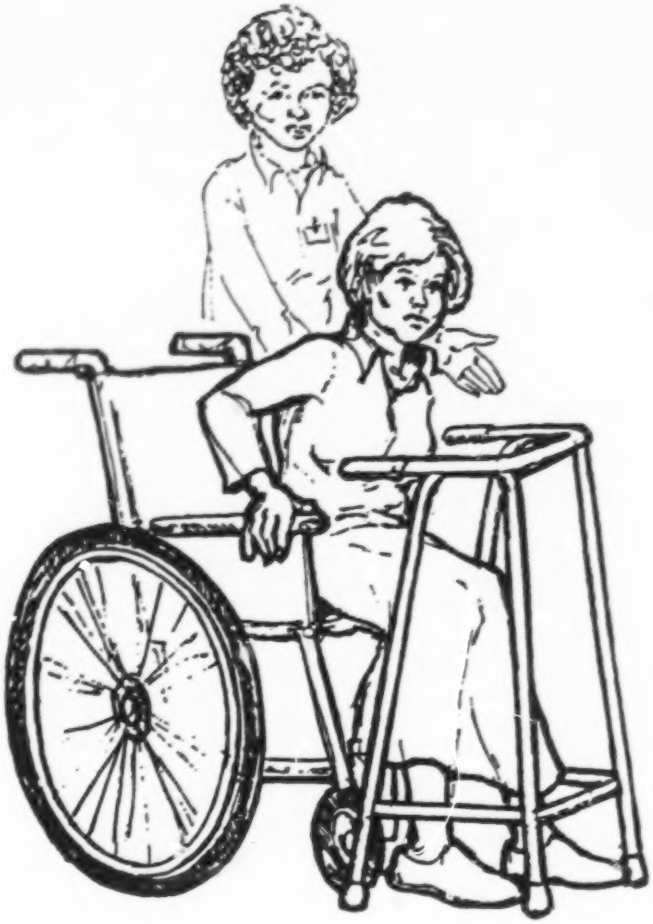
# Assisting the Hemiplegic

## Resident to Sit with a Cane



# Assisting the Weak Resident

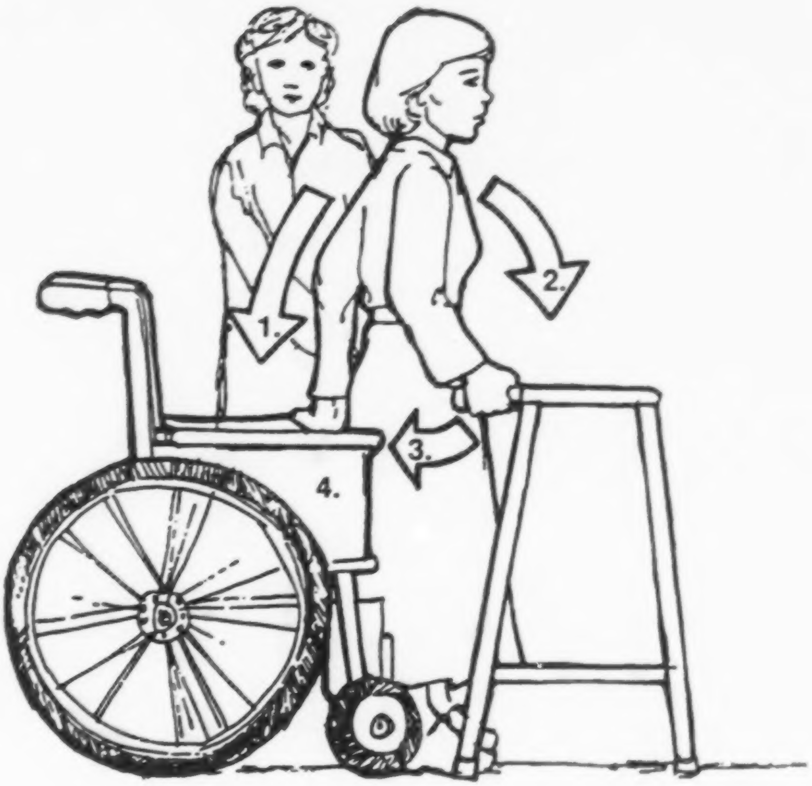
## to Stand with a Walker



1. Hands on armrests.
2. Flex trunk forward.
3. Push with arms and legs to stand.
4. Steady - place hands on walker.

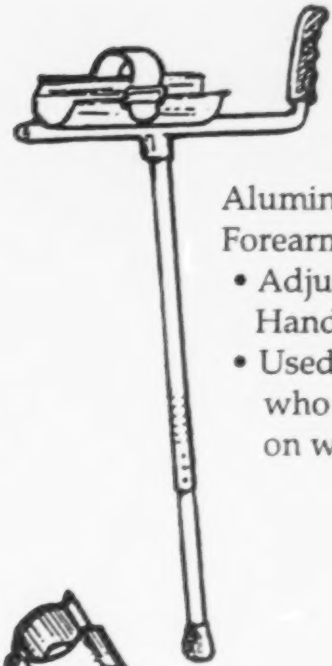
# Assisting the Weak Resident

## to Sit with a Walker



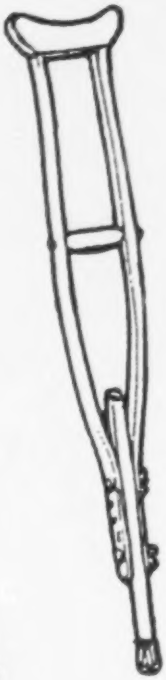
1. Reach back with one hand to armrest.
2. Flex trunk-weight over feet.
3. Reach back with other hand to armrest.
4. Sit-reposition in wheelchair for comfort.

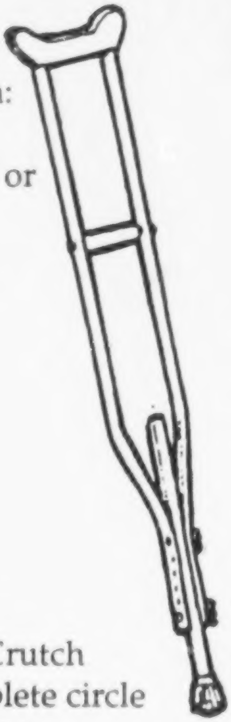
# Crutches



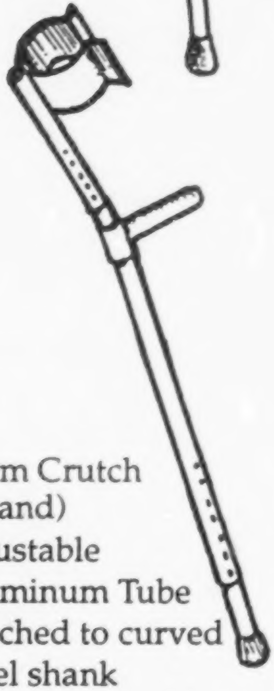
Aluminum Trough
Forearm Crutch
- Adjustable
  Handle on trough
- Used with residents who cannot put weight on wrist and hand

Wooden Crutch: Adjustable

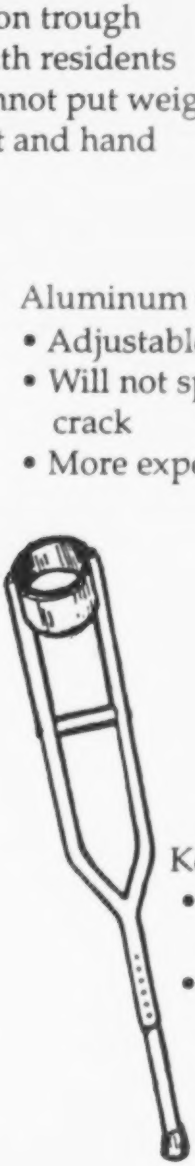




Aluminum Crutch:
- Adjustable
- Will not splinter or crack
- More expensive



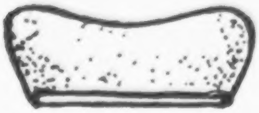
Forearm Crutch
(Lofstrand)
- Adjustable
  Aluminum Tube
  attached to curved
  steel shank
- Rubber covered hand bar
- Metal Forearm Cuff
- Used when resident needs more support than a cane, but not two crutches



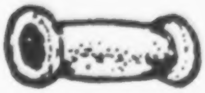
Kenny Crutch
- Complete circle cuff at top
- Used with polio and some CP residents

HO 2

# Accessories



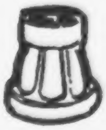
Axillary Pads

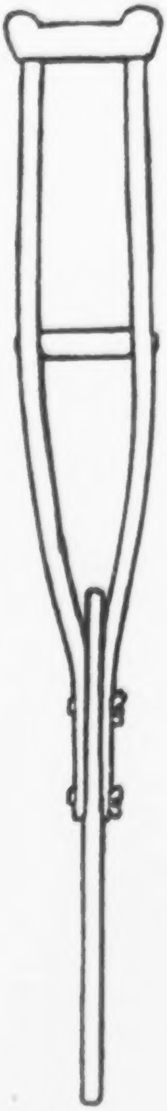


Hand Grip Pads

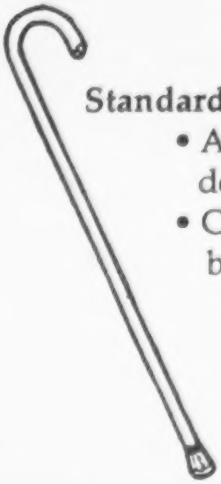
Rubber Tips:

- Use large safety grip
- Will hold at any angle



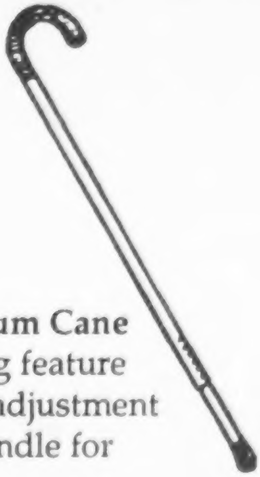


# Canes



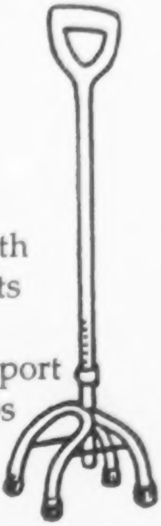
**Standard Wooden Cane**

- Adjust by cutting to desired length
- Curved handle for better grip



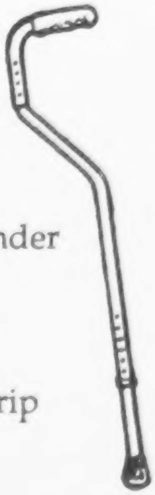
**Standard Aluminum Cane**

- Telescoping feature allows for adjustment
- Curved handle for better grip



**Quad Cane**

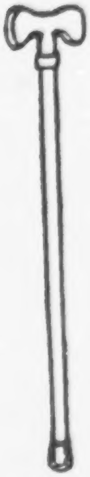
- Adjustable length
- Four leg-contacts with floor
- Gives more support as long as all tips contact floor



**Ortho-Cane**

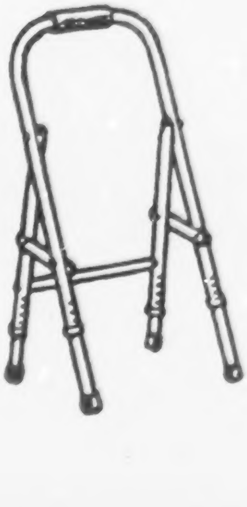
- Places weight under patient's hand
- Greater balance and control
- Can use ortho-grip

FUNCTIONAL GRIP CANES



**"T" Cane**

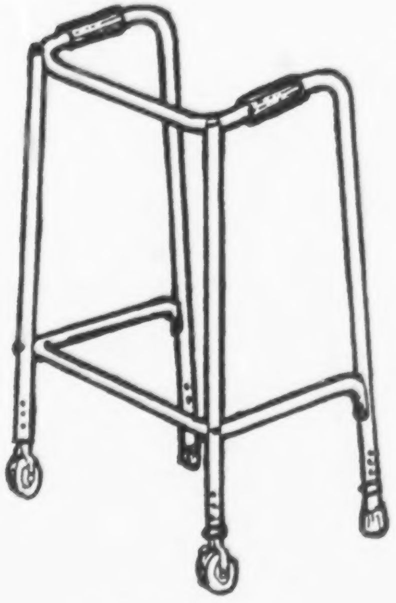
- Functional grip handle



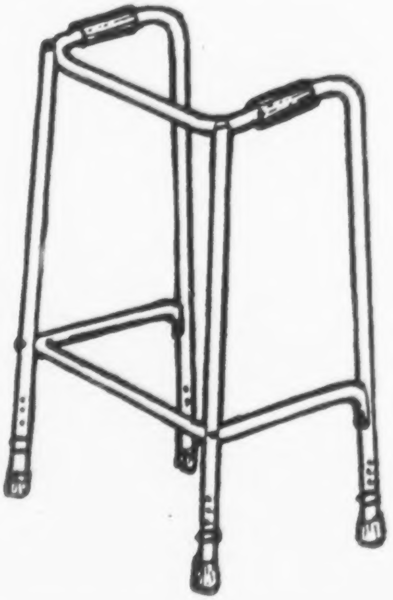
**Walk Cane**

- Combination of walker and cane

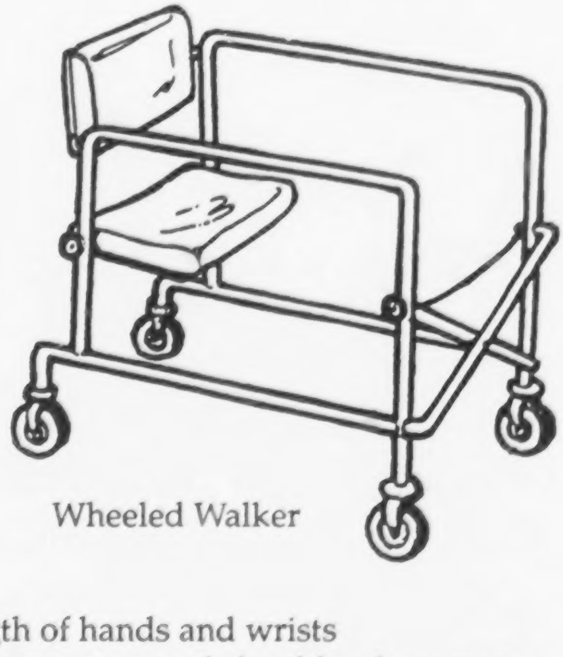
# Walkers



Rolling Walker



Standard Pick Up Walker



Wheeled Walker

- Requires partial strength of hands and wrists
- Requires strong elbow extensors and shoulder depressors

LESSON PLAN: 14

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

SCOPE OF UNIT:

This unit covers all aspects of restorative procedures carried out by the restorative nurse assistant. It includes a review of safety measures and precautions, positioning techniques, self-care skills, transfers, cognitive retraining, feeding, exercise, and maintaining medical records.

INFORMATION TOPIC: VII-14 OR DEMONSTRATION:

## TERMINOLOGY AND RECORD KEEPING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define abbreviations and symbols presented in this lesson.
2. List four characteristics of a well-written chart note.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Sample Chart Notes Written by the RNA

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia. Rev. 1987. Review Unit I, Lesson Plan 4, "Charting on Medical Records," with particular emphasis on "Basic Rules."

Review Unit VII, Lesson Plan 3, "Observation and Reporting," from this manual.

REFERENCES: (Instructor's Additional Information)

Abbreviation list from Harry S. Truman Veteran's Memorial Hospital in conformance with standard for accreditation as published by the Joint Commission on Accreditation of Hospitals, Gen. Adm. 136-83-43. June 1, 1982.

Nurse Assistant in a Long-Term Care Facility. Columbia: Instructional Materials Laboratory, University of Missouri - Columbia. Rev. 1987.

INTRODUCTION:

As a restorative nurse assistant, you will be required to read and write chart notes regarding a resident's restorative therapy. Clear verbal and written communication among staff, consultants, and physicians is essential for top quality resident care. In this lesson, we will be discussing abbreviations and symbols used in charting and various aspects of efficient, effective record keeping.

LESSON PLAN: 14

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

OUTLINE: (Key Points)

I. Abbreviations and Symbols (II-1)

- A. Time
    1. @ - at
    2. $\bar{a}$ - before
    3. a.c. - before meals
    4. b.i.d. - two times daily
    5. t.i.d. - three times daily
    6. o.d. - once daily
    7. $\bar{p}$ - after
    8. p.c. after meals
    9. q - every
    10. q. 2 h. - every two hours
    11. q. a.m. - every morning
    12. q.n. - every night
    13. q.o.d. - every other day
    14. ASAP - as soon as possible
    15. p.r.n. - whenever necessary
    16. b.i.w. - two times weekly
    17. t.i.w. - three times weekly
- B. Activities of daily living and exercises
    1. ADL - activities of daily living
    2. Abd. - abduction
    3. Add. - adduction

4. AAE - active assistive exercise
5. A/E - above the elbow
6. A/K - above the knee
7. AAROM - active-assistive range of motion
8. AROM - active range of motion
9. B/K - below the knee
10. c/o - complains of
11. Ext. - extension
12. Flex. - flexion
13. LE - lower extremity
14. LLE - left lower extremity
15. LUE - left upper extremity
16. Mm - muscles
17. PRE - progressive resistive exercise
18. PROM - passive range of motion
19. Reps. - repetitions
20. RLE - right lower extremity
21. ROM - range of motion
22. RROM - resistive range of motion
23. RUE - right upper extremity
24. W/C - wheelchair
25. Amb. - ambulation
26. Ex. - exercise

C. Diseases and conditions

1. ALS - amyotrophic lateral sclerosis
2. CVA - cerebrovascular accident
3. DECUB - decubitus

4. HTN - hypertension
5. MS - multiple sclerosis
6. N.P.O. - nothing by mouth
7. OBS - organic brain syndrome
8. SNHL - sensorineural hearing loss
9. SOB - shortness of breath
10. TIA - transient ischemic attack
11. URI - upper respiratory infection

D. Evaluation and rehabilitation

1. d/c or d.c. - discharge
2. Dx. or dx. - diagnosis
3. eval. - evaluation
4. Hx. - history
5. OT - occupational therapy
6. PT - physical therapy
7. ST - speech therapy
8. Levels of independence (can also be used for amount of resistance)
    a. Min. - minimal
    b. Mod. - moderate
    c. Max. - maximal
    d. SBA - stand-by assistance
9. Ref. phys. - referring physician
10. Rehab. - rehabilitation
11. Rx - therapy
12. Tx - treatment
13. WNL - within normal limits
14. wks. - weeks

15. wt. - weight

E. Miscellaneous

1. c̄ - with
2. CNS - central nervous system
3. CT - computerized tomography
4. i.e. - that is
5. L - left
6. N/A - not applicable
7. ō - none
8. per - by
9. R - right
10. s̄ - without
11. cont. - continue
12. TLC - tender loving care

F. Symbols

1. ↓ - decrease
2. ↑ - increase
3. △ - change
4. = - equals
5. > - is greater than
6. < - is less than
7. ≈ - approximately
8. ≥ - is greater than or equal to
9. ≤ - is less than or equal to
10. 2° - secondary
11. x - times (i.e., 2-3x)

12. ⇄ - indicates direction of action (i.e., bed → w/c transfer and w/c → bed transfer can be written: bed ⇄ w/c)

## II. Charting

A. Reading and understanding - it is important to be aware of:

1. Orders for resident
2. Resident's special needs (i.e., physical and mental)
3. Resident's medical condition
4. Activities which have taken place relating to the resident - be aware of resident's schedule to avoid fatigue

B. Characteristics of good chart notes (II-2)

1. Objective - write what you see, not what you assume; concentrate on precise, measurable terms
2. Complete, yet concise - brief narrative; accurate and to the point
3. Clear - understandable; should make sense to any other staff member or consultant who reads it
4. Legible - write neatly so that others do not have to guess what you have written down
5. Grammatically correct - observe basic rules of grammar and punctuation
6. Spelled correctly - if you are not sure of the correct spelling of a word, look it up in the dictionary

C. Chart notes made by the RNA should: (HO 1) (II-3)

1. Include resident's remarks which might affect performance (always note date).
2. Communicate with therapists and staff; and reflect communications with other staff.
3. Document that maintenance or restorative care was provided as ordered (include special adaptive equipment or assistive devices needed).

4. Document resident's response to treatment including:

   a. Changes in performance (i.e., ↑ or ↓ in performance)

   b. Goals met, or progress toward goals

   c. New goals

III. Summary and Conclusion

   A. Abbreviations and symbols

   B. Charting

In this lesson we have discussed abbreviations and symbols used in charting as well as some aspects of maintaining medical records. At this point, trying to remember the abbreviations and symbols, deciding what to say in a chart note, and now to write the note may seem a bit confusing. However, with practice, writing will come more easily for you and you will see just how critical is it to communicate effectively through charting.

LESSON PLAN: 14

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

INTERACTION ITEMS:

1. Why is it important to know how to write abbreviations and be able to interpret them?

2. What are some features of a well-written chart note?

3. What are the purposes of restorative therapy chart notes?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES

Have students practice writing effective chart notes to communicate the following situations. They should use the abbreviations and guidelines presented in this lesson for making the note as efficient and effective as possible. Have the students use fictional names to sign the chart notes and turn them in to the instructor. Other students can then critique the chart notes informally.

1. You have helped Mrs. B. perform passive range of motion on her lower extremities. She did better on her left than on her right. You will keep doing this every other day as requested by the physical therapist.

2. Mr. S. showed increased performance on his activities of daily living, especially self-feeding. Toward the end of the meal, however, he became short of breath and the nurse was notified.

3. Ms. L. is a resident who suffered a left cerebrovascular accident with resulting right hemiparesis. She receives speech therapy, physical therapy, and occupational therapy once every day. Her speech is limited, she can't feed herself, and she uses a wheelchair. She has been depressed because of her illness, and needs lots of tender loving care.

LESSON PLAN: 14

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII: SPECIFIC RESTORATIVE TECHNIQUES

EVALUATION ITEMS:

Provide the proper abbreviations or symbols for the following:

1. Every other day ____________________
2. As soon as possible ____________________
3. Passive range of motion ____________________
4. Abduction ____________________
5. Wheelchair ____________________
6. Hypertension ____________________
7. History ____________________
8. With ____________________
9. Without ____________________
10. Treatment ____________________
11. Secondary ____________________
12. Times ____________________
13. Increase ____________________
14. Stand-by assistance ____________________
15. After meals ____________________

Interpret the following abbreviations or symbols.

16. @ ____________________
17. c/o ____________________
18. LLE ____________________
19. ROM ____________________
20. ADL ____________________
21. SOB ____________________

22. TIA

23. reps.

24. Dx

25. CVA

26. ↓

27. Δ

28. >

29. Ext.

30. A/E

31. List four characteristics of good chart notes.

a.

b.

c.

d.

LESSON PLAN: 14

COURSE TITLE: RESTORATIVE NURSE ASSISTANT

UNIT VII : SPECIFIC RESTORATIVE TECHNIQUES

ANSWERS TO EVALUATION ITEMS:

1. q.o.d.
2. ASAP
3. PROM
4. Abd.
5. W/C
6. HTN
7. Hx
8. $\bar{c}$
9. $\bar{s}$
10. tx
11. 2°
12. x
13. ↑
14. SBA
15. p.c.
16. at
17. Complains of
18. Left lower extremity
19. Range of motion
20. Activities of daily living
21. Shortness of breath
22. Transient ischemic attack
23. Repetitions
24. Diagnosis
25. Cerebrovascular accident
26. Decrease
27. Change
28. Greater than
29. Extension
30. Above the elbow
31. The student may list any four of the following:
    a. Objective
    b. Complete yet concise
    c. Clear
    d. Legible
    e. Grammatically correct
    f. Spelled correctly

# Sample Chart Notes

## Written by the RNA

1/1/00

Mrs. Smith wasn't feeling well today. She walked about half-way to the nurse's station and then had to rest and then walked back to her room. She then needed a little help to get back and forth from the bathroom. Will tell the therapist and nurse about her problems, and cont. Tx. 2-3x wkly.

Jane Doe, R.N.A.

1/1/00

Resident states she feels "tired" this a.m. Resident Amb. ≈ 55'x2 $\bar{c}$ SBA, using a rolling walker $\bar{c}$ a platform attachment ~~on~~ for the L.U.E. Resident required brief rest between Amb.'s. Transfers W/C ⇄ toilet $\bar{c}$ min. assist +1 (resident usually performs $\bar{c}$ SBA). Notified charge nurse and therapist of resident's c/o tiredness and ↓ in performance today. Advised ~~by~~ per therapist to cont. as prescribed 2-3x wkly, + cont. to advise of changes.

Janice Doe, R.N.A.

# GLOSSARY

## A

Active range of motion (AROM) - resident performs entire movement throughout patterns without assistance.

Active-assistive range of motion (AAROM) - same ROM patterns except the resident assists in the movement of the body part; requires support.

Activities of daily living (ADL) - activities that are performed in one's life on a daily basis.

Acuity - sharpness of a particular sense such as visual or auditory.

Alternative - another choice.

Ambulation - the act of walking.

Anatomy - the study of the structure of the body.

Anomia - inability to recall words.

Aphasia - language disorder resulting from damage or disease of the brain.

Apraxia - a motor planning problem; inability to perform certain skilled, purposeful movements even though motor power, sensation, and coordination may be normal.

Arthritis - inflammation of a joint, usually causing pain.

Articulation - the movements of speech organs used in producing a particular speech sound which cause interruption and modification of air stream necessary to produce speech.

Aspiration - the taking of anything into the lungs other than air (i.e. thin or thick liquids, solids).

Assistive device - an apparatus, machine, or object which is constructed to aid an individual in performing a specific function (i.e., eating, walking, communicating).

Attention span - focusing on a task for a particular length of time.

Auditory - having to do with the sense of hearing.

Auditory agnosia - difficulty recognizing anything heard even though hearing is sharp.

Autonomic - functionally independent without control.

## B

Balance - the ability to have complete control of the body as it moves through space.

Bolus - food which has been chewed.

Bone fracture - any break of a bone.

Broca's area - language center usually in the left hemisphere of the brain which controls planning and executing speech.

Bursitis - inflammation of the bursa, a structure found in many joints of the body.

## C

Cartilage - tough, strong tissue; found in nose, ears, and at the ends of bones.

Cataracts - clouding of the lens of the eye; corrected with lens implants following removal of the old lens.

Cerebral - having to do with the largest part of the brain.

Cholesteatoma - a cyst, on or near the eardrum.

Cochlea - organ of hearing.

Cognition - performance of mental skills required to comprehend and understand.

Communication - the exchange and understanding of information accomplished by sending and receiving messages.

Compensate - make up for a deficiency.

Contact guarding - resident requires hand contact because of occasional loss of balance (protective safeguard).

Contracture - fibrosis of the tendons and ligaments supporting the muscles or joints resulting in permanent loss of normal ROM.

Coordination - the synchronized functioning of interrelated organs and body parts (i.e., motor controlling center of brain which enables particular groups of muscles in the legs, trunk, and arms to work together for the performance of walking and other activities).

Cricopharyngeal sphincter - muscle which allows food to pass from throat to esophagus.

## D

Denial - the refusal to admit or acknowledge that something exists (i.e., a disability or disease).

Diagnosis - the kind of disease or medical condition a person has.

Disability - the loss of or lack of ability to perform mental or physical tasks which one can normally do (as a result of injury or disease).

Draping - to cover the resident so that only the area to be worked with is exposed and maximum privacy and warmth is maintained.

Dysarthria - speech impairment due to muscle weakness as a result of brain damage.

Dysphagia - difficulty swallowing.

## E

Ear drum - structures in the ear that work together to transmit sound to the inner ear.

Effectiveness - how well a treatment is working.

Electronic - using electricity or batteries.

Emotional - relating to one's feelings.

Emotional lability - tendency to cry or laugh inappropriately, usually due to brain damage.

Empathy - understanding the feelings of others without sharing them.

Endentulous - without teeth.

Endurance - the ability of a muscle (or generally, the body) to withstand stress and resist fatigue over long periods of time.

Esophagus - digestive canal leading from the throat to the stomach.

Ethical - working with accepted principles of right and wrong.

Eustacean tube - structure connecting the middle ear to the throat; responsible for regulating ear pressure.

Exercise - the performance of physical exertion for improvement of health or the correction of physical deformity due to illness/injury; performed activity of the muscles, voluntary, or otherwise.

## F

Factual (objective) information - observable and documented without bias or judgments from the observer.

Flaccidity - a condition in which muscles display weakness, laxity, and softness.

## G

Generalization - applying previously learned concepts to a variety of situations.

Glaucoma - increased intraocular pressure of the eye leading to blindness if unchecked.

Goal - the desired end result; what one hopes to accomplish.

Graphic - use of drawing or writing.

Gustatory - having to do with the sense of taste.

## H

Hard palate - roof of the mouth.

## I

Imprecise - not exact.

Independent - resident requires no assistance; performs activity safely alone and feels secure.

Inferential (subjective) information - includes observer's judgments and opinions.

## J

Joint - place where two bones meet.

## L

Lability - frequent mood swings usually associated with nervous system damage.

Laryngectomy - surgical removal of the larynx.

Larynx - voice box; protects lungs from being penetrated by anything but air.

Legal - relating to the law.

Ligament - sheet of tough tissue that holds bones together at the joints.

Long-term care resident (LTC resident) - a person who, due to aging or illness, receives or requires care and services furnished by a facility (ICF or SNF), and who lives at the facility.

**M**

Macular degeneration - spot on retina loses blood supply; receptors are damaged and central vision is lost.

Maintenance - keeping present function through specific drills, exercises, protocols, etc.

Mandible - lower jaw bone.

Maxilla - upper jaw bone.

Maximal assist - resident contributes little or nothing toward execution of activity, is totally dependent.

Minimal assist - resident requires small amount of help to accomplish activity.

Mobility - the ability of the resident to move a body part or, more generally, his/her whole body through space.

Modality - refers to special equipment which provides therapeutic sensations for treatment of residents (i.e., heat, pressure, cold, electrical stimulation, etc.)

Moderate assist - resident definitely requires help, but contributes half the effort.

Motivation - factors that influence one's choice of activity or type of behavior.

Mourning - normal grief which can be caused by the onset of an injury, disease or death of a loved one; reaction to loss.

Muscle - a type of tissue composed of cells or fibers which affects movement of an organ or part of the body.

Muscle tone - stream of impulses which maintains a partial contraction; keeps muscle in a functional position.

Myoneural junction - the site on a muscle cell or fiber where the nerve impulse from the brain tells the muscle to contract (shorten).

## O

Occupational therapy (OT) - the use of work-related skills to treat or train the physically or emotionally ill.

Olfactory - having to do with the sense of smell.

Oral - of the mouth.

Osteomyelitis - infection of the bone.

Osteoporosis - loss of minerals from bone.

Otitis media - middle ear infection.

Otosclerosis - disease of bones of the middle ear.

## P

Passive range of motion (PROM) - complete movement of the body part through ROM without assistance from the resident.

Pelvic girdle - includes hip bones and attachments for leg bones.

Peripheral - away from the center or middle.

Peristalsis - squeezing movement of esophagus which propels food to the stomach.

Perseveration - inability to stop a certain behavior.

Personal space - invisible space which surrounds each of us and serves as a buffer between the self and others.

Pharyngeal - of the throat.

Phonation - production of sound.

Physical - relating to the body and the functioning of the body.

Physical therapy (PT) - rehabilitation concerned with restoring function and prevention of disability; often involves the use of therapeutic agents like heat, cold, massage, and exercise.

Presbycusis - age-related hearing impairment.

Prognosis - projected amount of recovery expected.

Proprioception - the ability of the brain to receive and understand information concerning body movements and the position of the body and its parts; messages come from sensory nerve ends in the muscles and tendons.

Prosody - stress and intonation patterns of speech.

## R

Rehabilitation - the process of restoring an individual to his/her maximum level of independence following an accident, injury, or illness to all or part of the body or mind.

Resistive range of motion (RROM) - resident performs entire movement without assistance and with resistance from external forces (i.e., weights).

Resonance - the quality, intensity, and duration of a speech sound.

Respiration - source of energy for speech.

Restorative - returning/maintaining a resident to physical or mental health or consciousness.

## S

Self-concept - how a person views herself/himself.

Self-image - how one views himself/herself in relation to others.

Semicircular canals - sense organs for maintaining sense of balance.

Sensory stimulation - focusing the resident's attention to each of his/her senses; used to treat sensory, cognitive, perceptual problems.

Sign language - using hands to convey messages.

Spasticity - state of increased muscle tone which causes muscle to be stiff, awkward, and increasingly resistant to stretching.

Speech - verbal expression of one's thoughts.

Speech therapy - the study and treatment of defects and disorders of the voice and of impairments of written or spoken communication.

Sprain - injury to a ligament.

Stand-by assist - resident requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly).

Stoma - opening made in the neck exposing the trachea.

Strength - the maximum ability to apply or resist force; the ability of a muscle (or generally, the body) to carry a load.

Sympathy - having common feelings with or sharing the feelings of a resident.

## T

Tactile - having to do with the sense of touch.

Temporomandibular joint - connects the upper and lower jaw.

Tendon - a band or cord of white fibrous tissue which provides a firm attachment of the muscle to the bone.

Territorial behavior - the need for clearly defined personal space; gives privacy and allows for control.

Therapeutic - having medicinal or healing qualities; a healing agent.

Therapist/consultant - an individual who holds a license to practice as a rehabilitation professional (i.e., physical therapist, occupational therapist, speech therapist).

Tinnitus - ringing in the ears.

Transcutaneous electric nerve stimulation (TENS) - pain control modality involving electrodes placed on the skin which transmit electrical impulses to the nerve endings that block transmission of pain signals to the brain.

Transfers - methods of moving a resident from one surface to another.

Treatment - using specific techniques with the intention of improving function.

## U

Ultrasound - physical modality which provides deep heat to body structures.

Unable - resident lacks the necessary strength or mental capability to perform any part of the activity.

## V

Velum (soft palate) - located at the back of the mouth; closes off the nasal cavity during swallowing.

Vertebral discs - discs of the spinal column down the middle of the back.

Video fluoroscopy - moving x-ray of the swallowing process which enables the physician and therapists to study all phases of the resident's swallowing and determine if patient is aspirating.

Visual - having to do with the sense of sight.

Visual agnosia - difficulty recognizing anything seen even though vision is sharp.

Visual field - range or area that can be seen by an individual.

Visual imagery - being able to picture a scene in your mind and focus attention on it.

Vocal cords - ligaments located at the top of the larynx where phonation is produced.

**W**

Wernicke's area - language center usually in the left hemisphere of the brain which controls understanding speech and selecting items to communicate.